

Memorandum 96-34

Health Care Decisions: Preliminary Considerations

This memorandum marks the beginning of the study on health care decisionmaking and discusses some basic issues concerning the possible scope of the study. Some background materials are also included— you should retain these items in your files for future reference:

1. Uniform Health Care Decisions Act (1993).
2. *Comparison of California Advance Health-Care Directive Law to the Uniform Health-Care Decisions Act* (memorandum prepared for the Commission by Cynthia Bradford, a third-year student at Stanford Law School).
3. *1995 Comprehensive Power of Attorney Law*, 24 Cal. L. Revision Comm'n Reports 323 (1994) — the Commission's report on the Power of Attorney Law as enacted. (Included with Commissioners' copies only.)

Also attached as an exhibit is a letter from Antonia Graphos, Chair of the Incapacity Subcommittee of the State Bar Estate Planning, Trust and Probate Law Section, reaffirming the interest of the Section in working with the Commission on this study.

At the November 1995 meeting, the Commission restated its intention to consider health care decisions issues. In the early 1990s, when the Commission was working on its comprehensive revision of the power of attorney statutes, culminating in enactment of the Power of Attorney Law in 1994, Team 4 of the Executive Committee of the State Bar Estate Planning, Trust and Probate Law Section repeatedly urged the Commission to consider revision of the durable power of attorney for health care. In 1993, near the end of the Commission's study of powers of attorney for property and related issues, the National Conference of Commissioners on Uniform State Laws approved the Uniform Health-Care Decisions Act, and the State Bar Team urged the Commission to review it as part of the power of attorney study.

Substantive review of health care decisionmaking issues was deferred for consideration as the second part of the power of attorney study. This enabled

legislative enactment of the comprehensive restructuring of the power of attorney statutes without further delay and was also necessary in light of other legislative priorities.

The time has come for the Commission to consider the larger issues of the scope and priorities of this study so that the staff can begin work and interested persons and groups can marshal their efforts. We anticipate that expert practitioners and professional groups will raise a significant number of issues as they review the existing law. Following this meeting, the staff proposes to give notice of the commencement of the study and solicit proposals for revision of the law.

In terms of general scope, the staff proposes to consider three general areas: the law in other jurisdictions, the Uniform Health-Care Decisions Act, and inconsistencies and other problems in existing California law.

Review of More Recent Statutes in Other Jurisdictions

California's durable power of attorney for health care was the first of its kind, enacted on Commission recommendation in its basic form in 1983. Many other states have enacted legislation dealing with the issue of health care decisionmaking since that time. It would be useful to review this body of law for useful ideas. Preliminary work has already been started — Matthew Waddell, a third-year law student at the University of Pennsylvania, has been collecting the statutes of other states, in his work through Penn's Public Service Program.

In this connection, Ms. Graphos, Chair of the Incapacity Subcommittee of the State Bar Estate Planning, Trust and Probate Law Section, writes that "practical aspects of health care decision making available in many states are notably absent in California." (See Exhibit p. 1.)

Review of Uniform Health-Care Decisions Act

As noted above, the Uniform Health-Care Decisions Act (UHCDA) has been recommended for enactment in all the states. The Commission has a statutory duty to receive and consider proposals from the Uniform Law Commissioners. You may have noticed that one of the observers to the UHCDA drafting committee, Harley Spitler, was also a member of the State Bar Team that worked with the Commission on the Power of Attorney Law. The UHCDA should not simply be enacted in California without detailed review and revision necessary to coordinate it with existing provisions, including the durable power of attorney

for health care in the Probate Code and the Natural Death Act in the Health and Safety Code. Here, too, preliminary work has been done — Cynthia Bradford, a third-year Stanford law student, has prepared a useful catalog and analysis of the differences between the California law reflected in the durable power and the Natural Death Act and the new UHCDA, which is attached to this memorandum.

Coordination of Existing Statutes

There are technical problems in the existing statutes and a lack of coordination between the durable power of attorney for health care and the Natural Death Act directive and other statutes. Some of these issues are explored in Ms. Bradford's memorandum. Ms. Graphos mentions the multiplicity of provisions in existing law and the potential for inconsistency and lack of cohesiveness. (See Exhibit p. 1.)

Competency determinations. Another issue that arose late in the power of attorney study concerns competency determinations. Commissioner's may recall that the Executive Committee of the State Bar Estate Planning, Trust and Probate Law Section urged the Commission in 1993 to adopt the capacity definition from the UHCDA for the purposes of the Power of Attorney Law. (See, e.g., Memorandum 94-2, Exhibit pp. 25-26.) The language of the UHCDA was found to be inappropriate for that general purpose. Since that time, there have been some changes in the law governing judicial determinations of competence which should be considered in this study. See Due Process in Competence Determinations Act, 1995 Cal. Stat. ch. 842.

Technical problems within durable power of attorney for health care. The durable power of attorney for health care statute as recodified in the new Power of Attorney Law in the Probate Code is nearly identical to its Civil Code predecessor. The Commission resisted making changes in this law while working on the comprehensive statute because it was much more highly developed than the general law relating to powers of attorney for property and because the issues are quite different, even though they overlap in some areas. One or two minimal revisions concerning execution of powers of attorney that the Commission recommended in the interest of uniformity had to be dropped when the bill encountered significant "concern" in legislative committee hearings. But these issues still remain. We know that some interest groups, such as the California Medical Association, have a number of technical issues they would

like to see addressed, and Ms. Graphos' letter suggests that the State Bar will be making numerous recommendations for revision.

As the Commission get into the study and we familiarize ourselves with the law and the issues, the staff will prepare memorandums on individual topics, such as execution and witnessing requirements, competency determinations, scope of surrogate decisionmaking, enforcement of directives, and the like, drawing from relevant law in California as well as other jurisdictions and the uniform act, where relevant. No doubt we will receive proposals from the bar and others that open up new issues. If the study threatens to become too broad, of course, the Commission will need to limit it to what can reasonably be accomplished in the Legislature. But at this point, as we are soliciting input from interested persons, the staff would not try to anticipate what matters are appropriate.

Respectfully submitted,

Stan Ulrich
Assistant Executive Secretary

**ESTATE PLANNING, TRUST AND
PROBATE LAW SECTION
THE STATE BAR OF CALIFORNIA**



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May 2, 1996

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Re: LRC Review of Durable Powers of Attorney for Health Care

Ladies and Gentlemen:

The undersigned is currently the Chair of the Incapacity Subcommittee for the State Bar Estate Planning, Trust and Probate Law Section. The purpose of this letter is to urge the LRC to undertake the review and study of Durable Powers of Attorney for Health Care.

Last year our subcommittee noted no less than 140 code sections relating to or impacted by issues regarding medical treatment, surrogate decision making, health care providers, the Natural Death Act and probate court proceedings related thereto. It is clear that the various statutory schemes may not be cohesive or consistent, that practical aspects of health care decision making available in many states are notably absent in California and that this creates uncertainty for legal practitioners in advising their clients, many of whom moved to California having executed health care documents consistent with other state law.

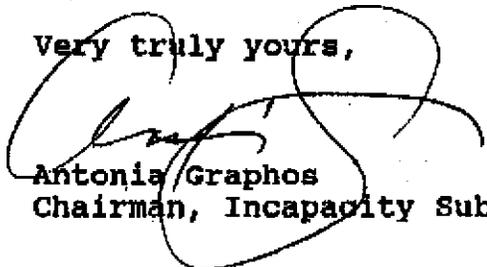
If the LRC goes forward with this project, rest assured that our Committee would welcome the opportunity to work with you in a collaborative fashion, in much the same way that we worked together on the property powers project which commenced in 1991. Indeed, a health care powers project such as the one under consideration is consistent

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with our Section's understanding of the LRC's commitment to follow up with such a health care powers project.

Please feel free to contact me to discuss this matter further and specifically to discuss any aspect of assistance which the Executive Committee members can provide to this most important project.

Very truly yours,



Antonia Graphos
Chairman, Incapacity Subcommittee

AG:nrs

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UNIFORM HEALTH-CARE DECISIONS ACT

Drafted by the

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ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT
IN ALL THE STATES

at its

ANNUAL CONFERENCE
MEETING IN ITS ONE-HUNDRED-AND-SECOND YEAR
IN CHARLESTON, SOUTH CAROLINA
JULY 30 - AUGUST 6, 1993



WITH PREFATORY NOTE AND COMMENTS

Approved by the American Bar Association
Kansas City, Missouri, February 7, 1994

UNIFORM HEALTH-CARE DECISIONS ACT

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UNIFORM HEALTH-CARE DECISIONS ACT

PREFATORY NOTE

Since the Supreme Court's decision in *Cruzan v. Commissioner, Missouri Department of Health*, 497 U.S. 261 (1990), significant change has occurred in state legislation on health-care decision making. Every state now has legislation authorizing the use of some sort of advance health-care directive. All but a few states authorize what is typically known as a living will. Nearly all states have statutes authorizing the use of powers of attorney for health care. In addition, a majority of states have statutes allowing family members, and in some cases close friends, to make health-care decisions for adult individuals who lack capacity.

This state legislation, however, has developed in fits and starts, resulting in an often fragmented, incomplete, and sometimes inconsistent set of rules. Statutes enacted within a state often conflict and conflicts between statutes of different states are common. In an increasingly mobile society where an advance health-care directive given in one state must frequently be implemented in another, there is a need for greater uniformity.

The Health-Care Decisions Act was drafted with this confused situation in mind. The Act is built around the following concepts. *First*, the Act acknowledges the right of a competent individual to decide all aspects of his or her own health care in all circumstances, including the right to decline health care or to direct that health care be discontinued, even if death ensues. An individual's instructions may extend to any and all health-care decisions that might arise and, unless limited by the principal, an agent has authority to make all health-care decisions which the individual could have made. The Act recognizes and validates an individual's authority to define the scope of an instruction or agency as broadly or as narrowly as the individual chooses.

Second, the Act is comprehensive and will enable an enacting jurisdiction to replace its existing legislation on the subject with a single statute. The Act authorizes health-care decisions to be made by an agent who is designated to decide when an individual cannot or does not wish to; by a designated surrogate, family member, or close friend when an individual is unable to act and no guardian or agent has been appointed or is reasonably available; or by a court having jurisdiction as decision maker of last resort.

Third, the Act is designed to simplify and facilitate the making of advance health-care directives. An instruction may be either written or oral. A power of attorney for health care, while it must be in writing, need not be witnessed or acknowledged. In addition, an optional form for the making of a directive is provided.

Fourth, the Act seeks to ensure to the extent possible that decisions about an individual's health care will be governed by the individual's own desires concerning the issues to be resolved. The Act requires an agent or surrogate authorized to make health-care decisions for an individual to make those decisions in accordance with the instructions and other wishes of the individual to the extent known. Otherwise, the agent or surrogate must make those decisions in accordance with the best interest of the individual but in light of the individual's personal values known to the agent or surrogate. Furthermore, the Act requires a guardian to comply with a ward's previously given instructions and prohibits a guardian from revoking the ward's advance health-care directive without express court approval.

Fifth, the Act addresses compliance by health-care providers and institutions. A health-care provider or institution must comply with an instruction of the patient and with a reasonable interpretation of that instruction or other health-care decision made by a person then authorized to make

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health-care decisions for the patient. The obligation to comply is not absolute, however. A health-care provider or institution may decline to honor an instruction or decision for reasons of conscience or if the instruction or decision requires the provision of medically ineffective care or care contrary to applicable health-care standards.

Sixth, the Act provides a procedure for the resolution of disputes. While the Act is in general to be effectuated without litigation, situations will arise where resort to the courts may be necessary. For that reason, the Act authorizes the court to enjoin or direct a health-care decision or order other equitable relief and specifies who is entitled to bring a petition.

The Health-Care Decisions Act supersedes the Commissioners' Model Health-Care Consent Act (1982), the Uniform Rights of the Terminally Ill Act (1985), and the Uniform Rights of the Terminally Ill Act (1989). A state enacting the Health-Care Decisions Act which has one of these other acts in force should repeal it upon enactment.

SECTION 1. DEFINITIONS. In this [Act]:

- (1) "Advance health-care directive" means an individual instruction or a power of attorney for health care.
- (2) "Agent" means an individual designated in a power of attorney for health care to make a health-care decision for the individual granting the power.
- (3) "Capacity" means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision.
- (4) "Guardian" means a judicially appointed guardian or conservator having authority to make a health-care decision for an individual.
- (5) "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual's physical or mental condition.
- (6) "Health-care decision" means a decision made by an individual or the individual's agent, guardian, or surrogate, regarding the individual's health care, including:
 - (i) selection and discharge of health-care providers and institutions;
 - (ii) approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
 - (iii) directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care.
- (7) "Health-care institution" means an institution, facility, or agency licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business.
- (8) "Health-care provider" means an individual licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession.
- (9) "Individual instruction" means an individual's direction concerning a health-care decision for the individual.
- (10) "Person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.
- (11) "Physician" means an individual authorized to practice medicine [or osteopathy] under [appropriate statute].
- (12) "Power of attorney for health care" means the designation of an agent to make health-care decisions for the individual granting the power.
- (13) "Primary physician" means a physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility.
- (14) "Reasonably available" means readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health-care needs.

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(15) "State" means a State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(16) "Supervising health-care provider" means the primary physician or, if there is no primary physician or the primary physician is not reasonably available, the health-care provider who has undertaken primary responsibility for an individual's health care.

(17) "Surrogate" means an individual, other than a patient's agent or guardian, authorized under this [Act] to make a health-care decision for the patient.

Comment

The term "advance health-care directive" (subsection (1)) appears in the federal Patient Self-Determination Act enacted as sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 and has gained widespread usage among health-care professionals.

The definition of "agent" (subsection (2)) is not limited to a single individual. The Act permits the appointment of co-agents and alternate agents.

The definition of "guardian" (subsection (4)) recognizes that some states grant health-care decision making authority to a conservator of the person.

The definition of "health care" (subsection (5)) is to be given the broadest possible construction. It includes the types of care referred to in the definition of "health-care decision" (subsection (6)), and to care, including custodial care, provided at a "health-care institution" (subsection (7)). It also includes non-medical remedial treatment such as practiced by adherents of Christian Science.

The term "health-care institution" (subsection (7)) includes a hospital, nursing home, residential-care facility, home health agency or hospice.

The term "individual instruction" (subsection (9)) includes any type of written or oral direction concerning health-care treatment. The direction may range from a written document which is intended to be effective at a future time if certain specified conditions arise and for which a form is provided in Section 4, to the written consent required before surgery is performed, to oral directions concerning care

recorded in the health-care record. The instruction may relate to a particular health-care decision or to health care in general.

The definition of "person" (subsection (10)) includes a limited liability company, which falls within the category of "other legal or commercial entity."

Because states differ on the classes of professionals who may lawfully practice medicine, the definition of "physician" (subsection (11)) cross-references the appropriate licensing or other statute.

The Act employs the term "primary physician" (subsection (13)) instead of "attending physician." The term "attending physician" could be understood to refer to any physician providing treatment to the individual, and not to the physician whom the individual, or agent, guardian, or surrogate, has designated or, in the absence of a designation, the physician who has undertaken primary responsibility for the individual's health care.

The term "reasonably available" (subsection (14)) is used in the Act to accommodate the reality that individuals will sometimes not be timely available. The term is incorporated into the definition of "supervising health-care provider" (subsection (16)). It appears in the optional statutory form (Section 4) to indicate when an alternate agent may act. In Section 5 it is used to determine when a surrogate will be authorized to make health-care decisions for an individual, and if so, which class of individuals has authority to act.

The definition of "supervising health-care provider" (subsection (16)) accommodates the circumstance that frequently arises where care

or supervision by a physician may not be readily available. The individual's primary physician is to assume the role, however, if reasonably available. For the contexts in which the term is used, see Sections 3, 5, and 7.

(17)) refers to the individual having present authority under Section 5 to make a health-care decision for a patient. It does not include an individual who might have such authority under a given set of circumstances which have not occurred.

The definition of "surrogate" (subsection

SECTION 2. ADVANCE HEALTH-CARE DIRECTIVES.

(a) An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

(b) An adult or emancipated minor may execute a power of attorney for health care, which may authorize the agent to make any health-care decision the principal could have made while having capacity. The power must be in writing and signed by the principal. The power remains in effect notwithstanding the principal's later incapacity and may include individual instructions. Unless related to the principal by blood, marriage, or adoption, an agent may not be an owner, operator, or employee of [a residential long-term health-care institution] at which the principal is receiving care.

(c) Unless otherwise specified in a power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity, and ceases to be effective upon a determination that the principal has recovered capacity.

(d) Unless otherwise specified in a written advance health-care directive, a determination that an individual lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent, must be made by the primary physician.

(e) An agent shall make a health-care decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

(f) A health-care decision made by an agent for a principal is effective without judicial approval.

(g) A written advance health-care directive may include the individual's nomination of a guardian of the person.

(h) An advance health-care directive is valid for purposes of this [Act] if it complies with this [Act], regardless of when or where executed or communicated.

Comment

The individual instruction authorized in subsection (a) may but need not be limited to take effect in specified circumstances, such as if the individual is dying. An individual instruction may be either written or oral.

Subsection (b) authorizes a power of attorney for health care to include instructions regarding

the principal's health care. This provision has been included in order to validate the practice of designating an agent and giving individual instructions in one document instead of two. The authority of an agent falls within the discretion of the principal as expressed in the instrument creating the power and may extend to any

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health-care decision the principal could have made while having capacity.

Subsection (b) excludes the oral designation of an agent. Section 5(b) authorizes an individual to orally designate a surrogate by personally informing the supervising health-care provider. A power of attorney for health care, however, must be in writing and signed by the principal, although it need not be witnessed or acknowledged.

Subsection (b) also limits those who may serve as agents to make health-care decisions for another. The subsection addresses the special vulnerability of individuals in residential long-term health-care institutions by protecting a principal against those who may have interests that conflict with the duty to follow the principal's expressed wishes or to determine the principal's best interest. Specifically, the owners, operators or employees of a residential long-term health-care institution at which the principal is receiving care may not act as agents. An exception is made for those related to the principal by blood, marriage or adoption, relationships which are assumed to neutralize any consequence of a conflict of interest adverse to the principal. The phrase "a residential long-term health-care institution" is placed in brackets to indicate to the legislature of an enacting jurisdiction that it should substitute the appropriate terminology used under local law.

Subsection (c) provides that the authority of the agent to make health-care decisions ordinarily does not become effective until the principal is determined to lack capacity and ceases to be effective should the principal recover capacity. A principal may provide, however, that the authority of the agent becomes effective immediately or upon the happening of some event other than the loss of capacity but may do so only by an express provision in the power of attorney. For example, a mother who does not want to make her own health-care decisions but prefers that her daughter make them for her may specify that the daughter as agent is to have authority to make health-care decisions immediately. The mother in that circumstance

retains the right to later revoke the power of attorney as provided in Section 3.

Subsection (d) provides that unless otherwise specified in a written advance health-care directive, a determination that a principal has lost or recovered capacity to make health-care decisions must be made by the primary physician. For example, a principal might specify that the determination of capacity is to be made by the agent in consultation with the primary physician. Or a principal, such as a member of the Christian Science faith who relies on a religious method of healing and who has no primary physician, might specify that capacity be determined by other means. In the event that multiple decision makers are specified and they cannot agree, it may be necessary to seek court instruction as authorized by Section 14.

Subsection (d) also provides that unless otherwise specified in a written advance health-care directive, the existence of other conditions which affect an individual instruction or the authority of an agent must be determined by the primary physician. For example, an individual might specify that an agent may withdraw or withhold treatment that keeps the individual alive only if the individual has an incurable and irreversible condition that will result in the individual's death within a relatively short time. In that event, unless otherwise specified in the advance health-care directive, the determination that the individual has that condition must be made by the primary physician.

Subsection (e) requires the agent to follow the principal's individual instructions and other expressed wishes to the extent known to the agent. To the extent such instructions or other wishes are unknown, the agent must act in the principal's best interest. In determining the principal's best interest, the agent is to consider the principal's personal values to the extent known to the agent. The Act does not prescribe a detailed list of factors for determining the principal's best interest but instead grants the agent discretion to ascertain and weigh the factors likely to be of importance to the principal. The legislature of an enacting jurisdiction that

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wishes to add such a list may want to consult the Maryland Health-Care Decision Act, Md. Health-Gen. Code Ann. § 5-601.

Subsection (f) provides that a health-care decision made by an agent is effective without judicial approval. A similar provision applies to health-care decisions made by surrogates (Section 5(g)) or guardians (Section 6(c)).

Subsection (g) provides that a written advance health-care directive may include the individual's nomination of a guardian of the person. A nomination cannot guarantee that the nominee will be appointed but in the absence of cause to appoint another the court would likely select the nominee. Moreover, the mere nomi-

nation of the agent will reduce the likelihood that a guardianship could be used to thwart the agent's authority.

Subsection (h) validates advance health-care directives which conform to the Act, regardless of when or where executed or communicated. This includes an advance health-care directive which would be valid under the Act but which was made prior to the date of its enactment and failed to comply with the execution requirements then in effect. It also includes an advance health-care directive which was made in another jurisdiction but which does not comply with that jurisdiction's execution or other requirements.

SECTION 3. REVOCATION OF ADVANCE HEALTH-CARE DIRECTIVE.

(a) An individual may revoke the designation of an agent only by a signed writing or by personally informing the supervising health-care provider.

(b) An individual may revoke all or part of an advance health-care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

(c) A health-care provider, agent, guardian, or surrogate who is informed of a revocation shall promptly communicate the fact of the revocation to the supervising health-care provider and to any health-care institution at which the patient is receiving care.

(d) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as agent unless otherwise specified in the decree or in a power of attorney for health care.

(e) An advance health-care directive that conflicts with an earlier advance health-care directive revokes the earlier directive to the extent of the conflict.

Comment

Subsection (b) provides that an individual may revoke any portion of an advance health-care directive at any time and in any manner that communicates an intent to revoke. However, a more restrictive standard applies to the revocation of the portion of a power of attorney for health care relating to the designation of an agent. Subsection (a) provides that an individual may revoke the designation of an agent only by a signed writing or by personally informing the supervising health-care provider. This higher standard is justified by the risk of a false revocation of an agent's designation or of a misinterpretation or miscommunication of a

principal's statement communicated through a third party. For example, without this higher standard, an individual motivated by a desire to gain control over a patient might be able to assume authority to act as agent by falsely informing a health-care provider that the principal no longer wishes the previously designated agent to act but instead wishes to appoint the individual.

Subsection (c) requires any health-care provider, agent, guardian or surrogate who is informed of a revocation to promptly communicate that fact to the supervising health-care provider and to any health-care institution at

which the patient is receiving care. The communication triggers the Section 7(b) obligation of the supervising health-care provider to record the revocation in the patient's health-care record and reduces the risk that a health-care provider or agent, guardian or surrogate will rely on a health-care directive that is no longer valid.

Subsection (e) establishes a rule of construction permitting multiple advance health-care directives to be construed together in order to

determine the individual's intent, with the later advance health-care directive superseding the former to the extent of any inconsistency.

The section does not specifically address amendment of an advance health-care directive because such reference is not necessary. Subsection (b) specifically authorizes partial revocation, and subsection (e) recognizes that an advance health-care directive may be modified by a later directive.

SECTION 4. OPTIONAL FORM. The following form may, but need not, be used to create an advance health-care directive. The other sections of this [Act] govern the effect of this or any other writing used to create an advance health-care directive. An individual may complete or modify all or any part of the following form:

ADVANCE HEALTH-CARE DIRECTIVE

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of [a residential long-term health-care institution] at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- (b) select or discharge health-care providers and institutions;
- (c) approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
- (d) direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration,

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as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. It is recommended but not required that you request two other individuals to sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

(name of individual you choose as agent)

(address)	(city)	(state)	(zip code)
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(home phone)	(work phone)
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OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

(name of individual you choose as first alternate agent)

(address)	(city)	(state)	(zip code)
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(home phone)	(work phone)
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OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

(name of individual you choose as second alternate agent)

(address)	(city)	(state)	(zip code)
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(home phone)	(work phone)
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(2) **AGENT'S AUTHORITY:** My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

(3) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [], my agent's authority to make health-care decisions for me takes effect immediately.

(4) **AGENT'S OBLIGATION:** My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) **NOMINATION OF GUARDIAN:** If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) **END-OF-LIFE DECISIONS:** I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

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(a) Choice Not To Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, OR

(b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) **ARTIFICIAL NUTRITION AND HYDRATION:** Artificial nutrition and hydration must be provided, withheld, or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box , artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) **RELIEF FROM PAIN:** Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(9) **OTHER WISHES:** (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)

**PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)**

(10) Upon my death (mark applicable box)

(a) I give any needed organs, tissues, or parts, OR

(b) I give the following organs, tissues, or parts only

(c) My gift is for the following purposes (strike any of the following you do not want)

(i) Transplant

(ii) Therapy

(iii) Research

(iv) Education

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PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

(11) I designate the following physician as my primary physician:

(name of physician)

(address)	(city)	(state)	(zip code)
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(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name of physician)

(address)	(city)	(state)	(zip code)
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(phone)

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) SIGNATURES: Sign and date the form here:

(date)	(sign your name)
(address)	(print your name)
(city) (state)	

(Optional) SIGNATURES OF WITNESSES:

First witness	Second witness
(print name)	(print name)
(address)	(address)
(city) (state)	(city) (state)
(signature of witness)	(signature of witness)
(date)	(date)

Comment

The optional form set forth in this section incorporates the Section 2 requirements applicable to advance health-care directives. There are four parts to the form. An individual may complete all or any parts of the form. Any part of the form left blank is not to be given effect. For example, an individual may complete the instructions for health care part of the form alone. Or an individual may complete the power of attorney for health care part of the form alone. Or an individual may complete both the instructions and power of attorney for health care parts of the form. An individual may also, but need not, complete the parts of the form pertaining to donation of bodily organs and tissue and the designation of a primary physician.

Part 1, the power of attorney for health care, appears first on the form in order to ensure to the extent possible that it will come to the attention of a casual reader. This reflects the reality that the appointment of an agent is a more comprehensive approach to the making of health-care decisions than is the giving of an individual instruction, which cannot possibly anticipate all future circumstances which might arise.

Part 1 (1) of the power of attorney for health care form requires only the designation of a single agent, but with opportunity given to designate a single first alternate and a single second alternate, if the individual chooses. No provision is made in the form for the designation of co-agents in order not to encourage the practice.

Designation of co-agents is discouraged because of the difficulties likely to be encountered if the co-agents are not all readily available or do not agree. If co-agents are appointed, the instrument should specify that either is authorized to act if the other is not reasonably available. It should also specify a method for resolving disagreements.

Part 1 (2) of the power of attorney for health care form grants the agent authority to make all health-care decisions for the individual subject to any limitations which the individual may state in the form. Reference is made to artificial nutrition and hydration and other forms of treatment to keep an individual alive in order to ensure that the individual is aware that those are forms of health care that the agent would have the authority to withdraw or withhold absent specific limitation.

Part 1 (3) of the power of attorney for health care form provides that the agent's authority becomes effective upon a determination that the individual lacks capacity, but as authorized by Section 2(c) a box is provided for the individual to indicate that the authority of the agent takes effect immediately.

Part 1 (4) of the power of attorney for health care form directs the agent to make health-care decisions in accordance with the power of attorney, any instructions given by the individual in Part 2 of the form, and the individual's other wishes to the extent known to the agent. To the extent the individual's wishes in the matter are not known, the agent is to make health-care decisions based on what the agent determines to be in the individual's best interest. In determining the individual's best interest, the agent is to consider the individual's personal values to the extent known to the agent. Section 2(e) imposes this standard, whether or not it is included in the form, but its inclusion in the form will bring it to the attention of the individual granting the power, to the agent, to any guardian or surrogate, and to the individual's health-care providers.

Part 1 (5) of the power of attorney for health care form nominates the agent, if available,

able, and willing to act, otherwise the alternate agents in order of priority stated, as guardians of the person for the individual. This provision is included in the form for two reasons. First, if an appointment of a guardian becomes necessary the agent is the one whom the individual would most likely want to serve in that role. Second, the nomination of the agent as guardian will reduce the possibility that someone other than the agent will be appointed as guardian who could use the position to thwart the agent's authority.

Because the variety of treatment decisions to which health-care instructions may relate is virtually unlimited, Part 2 of the form does not attempt to be comprehensive, but is directed at the types of treatment for which an individual is most likely to have special wishes. Part 2(6) of the form, entitled "End-of-Life Decisions", provides two alternative choices for the expression of wishes concerning the provision, withholding, or withdrawal of treatment. Under the first choice, the individual's life is not to be prolonged if the individual has an incurable and irreversible condition that will result in death within a relatively short time, if the individual becomes unconscious and, to a reasonable degree of medical certainty, will not regain consciousness, or if the likely risks and burdens of treatment would outweigh the expected benefits. Under the second choice, the individual's life is to be prolonged within the limits of generally accepted health-care standards. Part 2(7) of the form provides a box for an individual to mark if the individual wishes to receive artificial nutrition and hydration in all circumstances. Part 2(8) of the form provides space for an individual to specify any circumstance when the individual would prefer not to receive pain relief. Because the choices provided in Parts 2(6) to 2(8) do not cover all possible situations, Part 2(9) of the form provides space for the individual to write out his or her own instructions or to supplement the instructions given in the previous subparts of the form. Should the space be insufficient, the individual is free to add additional pages.

The health-care instructions given in Part 2 of

the form are binding on the agent, any guardian, any surrogate, and, subject to exceptions specified in Section 7(e)-(f), on the individual's health-care providers. Pursuant to Section 7(d), a health-care provider must also comply with a reasonable interpretation of those instructions made by an authorized agent, guardian, or surrogate.

Part 3 of the form provides the individual an opportunity to express an intention to donate bodily organs and tissues at death. The options provided are derived from a suggested form in the Comment to Section 2 of the Uniform Anatomical Gift Act (1987).

Part 4 of the form provides space for the individual to designate a primary physician should the individual choose to do so. Space is also provided for the designation of an alternate primary physician should the first designated physician not be available, able, or willing to act.

Paragraph (12) of the form conforms with the provisions of Section 12 by providing that a copy of the form has the same effect as the original.

The Act does not require witnessing, but to

encourage the practice the form provides space for the signatures of two witnesses.

The form does not require formal acceptance by an agent. Formal acceptance by an agent has been omitted not because it is an undesirable practice but because it would add another stage to executing an advance health-care directive, thereby further reducing the number of individuals who will follow through and create directives. However, practitioners who wish to adapt this form for use by their clients are strongly encouraged to add a formal acceptance. Designated agents have no duty to act until they accept the office either expressly or through their conduct. Consequently, requiring formal acceptance reduces the risk that a designated agent will decline to act when the need arises. Formal acceptance also makes it more likely that the agent will become familiar with the principal's personal values and views on health care. While the form does not require formal acceptance, the explanation to the form does encourage principals to talk to the person they have named as agent to make certain that the designated agent understands their wishes and is willing to take the responsibility.

SECTION 5. DECISIONS BY SURROGATE.

(a) A surrogate may make a health-care decision for a patient who is an adult or emancipated minor if the patient has been determined by the primary physician to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available.

(b) An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health-care provider. In the absence of a designation, or if the designee is not reasonably available, any member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as surrogate:

- (1) the spouse, unless legally separated;
- (2) an adult child;
- (3) a parent; or
- (4) an adult brother or sister.

(c) If none of the individuals eligible to act as surrogate under subsection (b) is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available may act as surrogate.

(d) A surrogate shall communicate his or her assumption of authority as promptly as practica-

ble to the members of the patient's family specified in subsection (b) who can be readily contacted.

(e) If more than one member of a class assumes authority to act as surrogate, and they do not agree on a health-care decision and the supervising health-care provider is so informed, the supervising health-care provider shall comply with the decision of a majority of the members of that class who have communicated their views to the provider. If the class is evenly divided concerning the health-care decision and the supervising health-care provider is so informed, that class and all individuals having lower priority are disqualified from making the decision.

(f) A surrogate shall make a health-care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.

(g) A health-care decision made by a surrogate for a patient is effective without judicial approval.

(h) An individual at any time may disqualify another, including a member of the individual's family, from acting as the individual's surrogate by a signed writing or by personally informing the supervising health-care provider of the disqualification.

(i) Unless related to the patient by blood, marriage, or adoption, a surrogate may not be an owner, operator, or employee of [a residential long-term health-care institution] at which the patient is receiving care.

(j) A supervising health-care provider may require an individual claiming the right to act as surrogate for a patient to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed authority.

Comment

Subsection (a) authorizes a surrogate to make a health-care decision for a patient who is an adult or emancipated minor if the patient lacks capacity to make health-care decisions and if no agent or guardian has been appointed or the agent or guardian is not reasonably available. Health-care decision making for unemancipated minors is not covered by this section. The subject of consent for treatment of minors is a complex one which in many states is covered by a variety of statutes and is therefore left to other state law.

While a designation of an agent in a written power of attorney for health care is preferred, situations may arise where an individual will not be in a position to execute a power of attorney for health care. In that event, subsection (b) affirms the principle of patient autonomy by allowing an individual to designate a surrogate by personally informing the supervising health-care provider. The supervising health-care

provider would then, in accordance with Section 7(b), be obligated to promptly record the designation in the individual's health-care record. An oral designation of a surrogate made by a patient directly to the supervising health-care provider revokes a previous designation of an agent. See Section 3(a).

If an individual does not designate a surrogate or if the designee is not reasonably available, subsection (b) applies a default rule for selecting a family member to act as surrogate. Like all default rules, it is not tailored to every situation, but incorporates the presumed desires of a majority of those who find themselves so situated. The relationships specified in subsection (b) include those of the half-blood and by adoption, in addition to those of the whole blood.

Subsection (c) permits a health-care decision to be made by a more distant relative or unrelated adult with whom the individual enjoys a

close relationship but only if all family members specified in subsection (b) decline to act or are otherwise not reasonably available. Consequently, those in non-traditional relationships who want to make certain that health-care decisions are made by their companions should execute powers of attorney for health care designating them as agents or, if that has not been done, should designate them as surrogates.

Subsections (b) and (c) permit any member of a class authorized to serve as surrogate to assume authority to act even though there are other members in the class.

Subsection (d) requires a surrogate who assumes authority to act to immediately so notify the members of the patient's family who in given circumstances would be eligible to act as surrogate. Notice to the specified family members will enable them to follow health-care developments with respect to their now incapacitated relative. It will also alert them to take appropriate action, including the appointment of a guardian or the commencement of judicial proceedings under Section 14, should the need arise.

Subsection (e) addresses the situation where more than one member of the same class has assumed authority to act as surrogate and a disagreement over a health-care decision arises of which the supervising health-care provider is informed. Should that occur, the supervising health-care provider must comply with the decision of a majority of the members of that class who have communicated their views to the provider. If the members of the class who have communicated their views to the provider are evenly divided concerning the health-care decision, however, then the entire class is disqualified from making the decision and no individual having lower priority may act as surrogate. When such a deadlock arises, it may be necessary to seek court determination of the issue as authorized by Section 14.

Subsection (f) imposes on surrogates the

same standard for health-care decision making as is prescribed for agents in Section 2(e). The surrogate must follow the patient's individual instructions and other expressed wishes to the extent known to the surrogate. To the extent such instructions or other wishes are unknown, the surrogate must act in the patient's best interest. In determining the patient's best interest, the surrogate is to consider the patient's personal values to the extent known to the surrogate.

Subsection (g) provides that a health-care decision made by a surrogate is effective without judicial approval. A similar provision applies to health-care decisions made by agents (Section 2(f)) or guardians (Section 6(c)).

Subsection (h) permits an individual to disqualify any family member or other individual from acting as the individual's surrogate, including disqualification of a surrogate who was orally designated.

Subsection (i) disqualifies an owner, operator, or employee of a residential long-term health-care institution at which a patient is receiving care from acting as the patient's surrogate unless related to the patient by blood, marriage, or adoption. This disqualification is similar to that for appointed agents. See Section 2(b) and Comment.

Subsection (j) permits a supervising health-care provider to require an individual claiming the right to act as surrogate to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed relationship. The authority to request a declaration is included to permit the provider to obtain evidence of claimed authority. A supervising health-care provider, however, does not have a duty to investigate the qualifications of an individual claiming authority to act as surrogate, and Section 9(a) protects a health-care provider or institution from liability for complying with the decision of such an individual, absent knowledge that the individual does not in fact have such authority.

SECTION 6. DECISIONS BY GUARDIAN.

(a) A guardian shall comply with the ward's individual instructions and may not revoke the ward's advance health-care directive unless the appointing court expressly so authorizes.

(b) Absent a court order to the contrary, a health-care decision of an agent takes precedence over that of a guardian.

(c) A health-care decision made by a guardian for the ward is effective without judicial approval.

Comment

The Act affirms that health-care decisions should whenever possible be made by a person whom the individual selects to do so. For this reason, subsection (b) provides that a health-care decision of an agent takes precedence over that of a guardian absent a court order to the contrary, and subsection (a) provides that a guardian may not revoke the ward's power of attorney for health care unless the appointing court expressly so authorizes. Without these subsections, a guardian would in many states have authority to revoke the ward's power of attorney for health care even though the court appointing the guardian might not be aware that the principal had made such alternate arrangement.

The Act expresses a strong preference for honoring an individual instruction. Under the Act, an individual instruction must be honored by an agent, by a surrogate, and, subject to exceptions specified in Section 7(e)-(f), by an individual's health-care providers. Subsection (a) extends this principle to guardians by requir-

ing that a guardian effectuate the ward's individual instructions. A guardian may revoke the ward's individual instructions only if the appointing court expressly so authorizes.

Courts have no particular expertise with respect to health-care decision making. Moreover, the delay attendant upon seeking court approval may undermine the effectiveness of the decision ultimately made, particularly but not only when the patient's condition is life-threatening and immediate decisions concerning treatment need to be made. Decisions should whenever possible be made by a patient, or the patient's guardian, agent, or surrogate in consultation with the patient's health-care providers without outside interference. For this reason, subsection (c) provides that a health-care decision made by a guardian for the ward is effective without judicial approval, and the Act includes similar provisions for health-care decisions made by agents (Section 2(f)) or surrogates (Section 5(g)).

SECTION 7. OBLIGATIONS OF HEALTH-CARE PROVIDER.

(a) Before implementing a health-care decision made for a patient, a supervising health-care provider, if possible, shall promptly communicate to the patient the decision made and the identity of the person making the decision.

(b) A supervising health-care provider who knows of the existence of an advance health-care directive, a revocation of an advance health-care directive, or a designation or disqualification of a surrogate, shall promptly record its existence in the patient's health-care record and, if it is in writing, shall request a copy and if one is furnished shall arrange for its maintenance in the health-care record.

(c) A primary physician who makes or is informed of a determination that a patient lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the

authority of an agent, guardian, or surrogate, shall promptly record the determination in the patient's health-care record and communicate the determination to the patient, if possible, and to any person then authorized to make health-care decisions for the patient.

(d) Except as provided in subsections (e) and (f), a health-care provider or institution providing care to a patient shall:

- (1) comply with an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health-care decisions for the patient; and
- (2) comply with a health-care decision for the patient made by a person then authorized to make health-care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.

(e) A health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience. A health-care institution may decline to comply with an individual instruction or health-care decision if the instruction or decision is contrary to a policy of the institution which is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health-care decisions for the patient.

(f) A health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution.

(g) A health-care provider or institution that declines to comply with an individual instruction or health-care decision shall:

- (1) promptly so inform the patient, if possible, and any person then authorized to make health-care decisions for the patient;
- (2) provide continuing care to the patient until a transfer can be effected; and
- (3) unless the patient or person then authorized to make health-care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution that is willing to comply with the instruction or decision.

(h) A health-care provider or institution may not require or prohibit the execution or revocation of an advance health-care directive as a condition for providing health care.

Comment

Subsection (a) further reinforces the Act's respect for patient autonomy by requiring a supervising health-care provider, if possible, to promptly communicate to a patient, prior to implementation, a health-care decision made for the patient and the identity of the person making the decision.

The recording requirement in subsection (b) reduces the risk that a health-care provider or institution, or agent, guardian or surrogate, will rely on an outdated individual instruction or the decision of an individual whose authority has

been revoked.

Subsection (c) imposes recording and communication requirements relating to determinations that may trigger the authority of an agent, guardian or surrogate to make health-care decisions on an individual's behalf. The determinations covered by these requirements are those specified in Sections 2(c)-(d) and 5(a).

Subsection (d) requires health-care providers and institutions to comply with a patient's individual instruction and with a reasonable interpretation of that instruction made by a person

then authorized to make health-care decisions for the patient. A health-care provider or institution must also comply with a health-care decision made by a person then authorized to make health-care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity. These requirements help to protect the patient's rights to autonomy and self-determination and validate and seek to effectuate the substitute decision making authorized by the Act.

Not all instructions or decisions must be honored, however. Subsection (e) authorizes a health-care provider to decline to comply with an individual instruction or health-care decision for reasons of conscience. Subsection (e) also allows a health-care institution to decline to comply with a health-care instruction or decision if the instruction or decision is contrary to a policy of the institution which is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to an individual then authorized to make health-care decisions for the patient.

Subsection (f) further authorizes a health-care provider or institution to decline to comply with an instruction or decision that requires the provision of care which would be medically ineffective or contrary to generally accepted health-care standards applicable to the provider or

institution. "Medically ineffective health care", as used in this section, means treatment which would not offer the patient any significant benefit.

Subsection (g) requires a health-care provider or institution that declines to comply with an individual instruction or health-care decision to promptly communicate the refusal to the patient, if possible, and to any person then authorized to make health-care decisions for the patient. The provider or institution also must provide continuing care to the patient until a transfer can be effected. In addition, unless the patient or person then authorized to make health-care decisions for the patient refuses assistance, the health-care provider or institution must immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution that is willing to comply with the instruction or decision.

Subsection (h), forbidding a health-care provider or institution to condition provision of health care on execution, non-execution, or revocation of an advance health-care directive, tracks the provisions of the federal Patient Self-Determination Act (42 U.S.C. 1395cc(f)(1)(C) (Medicare); 42 U.S.C. § 1396a(w)(1)(C) (Medicaid)).

SECTION 8. HEALTH-CARE INFORMATION. Unless otherwise specified in an advance health-care directive, a person then authorized to make health-care decisions for a patient has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health-care information.

Comment

An agent, guardian, or surrogate stands in the shoes of the patient when making health-care decisions. To assure fully informed decision making, this section provides that a person who is then authorized to make health-care decisions

for a patient has the same right of access to health-care information as does the patient unless otherwise specified in the patient's advance health-care directive.

SECTION 9. IMMUNITIES.

(a) A health-care provider or institution acting in good faith and in accordance with generally accepted health-care standards applicable to the health-care provider or institution is not subject to

civil or criminal liability or to discipline for unprofessional conduct for:

(1) complying with a health-care decision of a person apparently having authority to make a health-care decision for a patient, including a decision to withhold or withdraw health care;

(2) declining to comply with a health-care decision of a person based on a belief that the person then lacked authority; or

(3) complying with an advance health-care directive and assuming that the directive was valid when made and has not been revoked or terminated.

(b) An individual acting as agent or surrogate under this [Act] is not subject to civil or criminal liability or to discipline for unprofessional conduct for health-care decisions made in good faith.

Comment

The section grants broad protection from liability for actions taken in good faith. Subsection (a) permits a health-care provider or institution to comply with a health-care decision made by a person appearing to have authority to make health care decisions for a patient; to decline to comply with a health-care decision made by a person believed to be without authority; and to assume the validity of and to comply with an advance health-care directive. Absent bad faith or actions taken that are not in accord with generally accepted health-care standards, a health-care provider or institution has no duty to investigate a claim of authority or the validity of an advance health-care directive.

Subsection (b) protects agents and surrogates acting in good faith from liability for making a health-care decision for a patient. Also protected from liability are individuals who mistakenly but in good faith believe they have the authority to make a health-care decision for a patient. For example, an individual who has been designated as agent in a power of attorney for health care might assume authority unaware that the power has been revoked. Or a family member might assume authority to act as surrogate unaware that a family member having a higher priority was reasonably available and authorized to act.

SECTION 10. STATUTORY DAMAGES.

(a) A health-care provider or institution that intentionally violates this [Act] is subject to liability to the aggrieved individual for damages of \$[500] or actual damages resulting from the violation, whichever is greater, plus reasonable attorney's fees.

(b) A person who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health-care directive or a revocation of an advance health-care directive without the individual's consent, or who coerces or fraudulently induces an individual to give, revoke, or not to give an advance health-care directive, is subject to liability to that individual for damages of \$[2,500] or actual damages resulting from the action, whichever is greater, plus reasonable attorney's fees.

Comment

Conduct which intentionally violates the Act and which interferes with an individual's autonomy to make health-care decisions, either personally or through others as provided under the Act, is subject to civil damages rather than criminal penalties out of a recognition that prosecutions are unlikely to occur. The legislature of an enacting state will have to determine the

amount of damages which needs to be authorized in order to encourage the level of potential private enforcement actions necessary to effect compliance with the obligations and responsibilities imposed by the Act. The damages provided by this section do not supersede but are in addition to remedies available under other law.

SECTION 11. CAPACITY.

(a) This [Act] does not affect the right of an individual to make health-care decisions while having capacity to do so.

(b) An individual is presumed to have capacity to make a health-care decision, to give or revoke an advance health-care directive, and to designate or disqualify a surrogate.

Comment

This section reinforces the principle of patient autonomy by providing a rebuttable presumption that an individual has capacity for all decisions relating to health care referred to in the Act.

SECTION 12. EFFECT OF COPY. A copy of a written advance health-care directive, revocation of an advance health-care directive, or designation or disqualification of a surrogate has the same effect as the original.

Comment

The need to rely on an advance health-care directive may arise at times when the original is inaccessible. For example, an individual may be receiving care from several health-care providers or may be receiving care at a location distant from that where the original is kept. To facilitate prompt and informed decision making, this section provides that a copy of a valid written advance health-care directive, revocation of an advance health-care directive, or designation or disqualification of a surrogate has the same effect as the original.

SECTION 13. EFFECT OF [ACT].

(a) This [Act] does not create a presumption concerning the intention of an individual who has not made or who has revoked an advance health-care directive.

(b) Death resulting from the withholding or withdrawal of health care in accordance with this [Act] does not for any purpose constitute a suicide or homicide or legally impair or invalidate a policy of insurance or an annuity providing a death benefit, notwithstanding any term of the policy or annuity to the contrary.

(c) This [Act] does not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of this State.

(d) This [Act] does not authorize or require a health-care provider or institution to provide health care contrary to generally accepted health-care standards applicable to the health-care provider or institution.

[(e) This [Act] does not authorize an agent or surrogate to consent to the admission of an individual to a mental health-care institution unless the individual's written advance health-care directive expressly so provides.]

[(f) This [Act] does not affect other statutes of this State governing treatment for mental illness of an individual involuntarily committed to a [mental health-care institution under appropriate statute].]

Comment

Subsection (e) is included to accommodate the legislature of an enacting jurisdiction that wishes to address in this Act rather than by separate statute the authority of an agent or surrogate to consent to the admission of an individual to a mental health-care institution. In recognition of the principle of patient autonomy, however, an individual may authorize an agent or surrogate to consent to an admission to a mental health-care institution but may do so only by express provision in an advance health-care directive. Subsection (e) does not address the authority of a guardian to consent to an

admission, leaving that matter to be decided under state guardianship law.

All states surround the involuntary commitment process with procedural safeguards. Moreover, state mental health codes contain detailed provisions relating to the treatment of individuals subject to commitment. Subsection (f) is included in the event that the legislature of an enacting jurisdiction wishes to clarify that a general health-care statute such as this Act is intended to supplement and not supersede these more detailed provisions.

SECTION 14. JUDICIAL RELIEF. On petition of a patient, the patient's agent, guardian, or surrogate, a health-care provider or institution involved with the patient's care, or an individual described in Section 5(b) or (c), the [appropriate] court may enjoin or direct a health-care decision or order other equitable relief. A proceeding under this section is governed by [here insert appropriate reference to the rules of procedure or statutory provisions governing expedited proceedings and proceedings affecting incapacitated persons].

Comment

While the provisions of the Act are in general to be effectuated without litigation, situations will arise where judicial proceedings may be appropriate. For example, the members of a class of surrogates authorized to act under Section 5 may be evenly divided with respect to the advisability of a particular health-care decision. In that circumstance, authorization to proceed may have to be obtained from a court. Examples of other legitimate issues that may from time to time arise include whether an agent or surrogate has authority to act and whether an agent or surrogate has complied with the standard of care imposed by Sections 2(e) and 5(f).

This section has a limited scope. The court under this section may grant only equitable relief. Other adequate avenues exist for those

who wish to pursue money damages. The class of potential petitioners is also limited to those with a direct interest in a patient's health care.

The final portion of this section has been placed in brackets in recognition of the fact that states vary widely in the extent to which they codify procedural matters in a substantive act. The legislature of an enacting jurisdiction is encouraged, however, to cross-reference to its rules on expedited proceedings or rules on proceedings affecting incapacitated persons. The legislature of an enacting jurisdiction which wishes to include a detailed procedural provision in its adoption of the Act may want to consult *Guidelines for State Court Decision Making in Life-Sustaining Medical Treatment Cases* (2d ed. 1992), published by the National Center for State Courts.

SECTION 15. UNIFORMITY OF APPLICATION AND CONSTRUCTION. This [Act] shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject matter of this [Act] among States enacting it.

SECTION 16. SHORT TITLE. This [Act] may be cited as the Uniform Health-Care Decisions Act.

SECTION 17. SEVERABILITY CLAUSE. If any provision of this [Act] or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

SECTION 18. EFFECTIVE DATE. This [Act] takes effect on

SECTION 19. REPEAL. The following acts and parts of acts are repealed:

- (1)
- (2)
- (3)

MEMORANDUM

**Comparison of California Advance Health-Care Directive Law
to the Uniform Health-Care Decisions Act**

by Cynthia Bradford
prepared for California Law Revision Commission

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1. INTRODUCTION

This memo compares and contrasts the legal approaches provided by California’s advance health-care directive law, found in the durable power of attorney for health care statutes and the “Natural Death Act,” to the Uniform Health-Care Decisions Act, a model bill drafted by the Uniform Law Commissioners that permits an individual to specify in advance his or her wishes and preferences regarding health care. Prob. Code §§ 4600-4806 (durable powers of attorney for health care), 4900-4948 (judicial proceedings concerning powers of attorney); Health & Safety Code §§ 7185.5-7194.5 (Natural Death Act); Uniform Health-Care Decisions Act (1993) (hereinafter “UHCDA”). Because each of the three advance health-care directive approaches discussed here is complex and lengthy, not all of the approaches’ respective sections and subdivisions will be addressed. Rather, the following discussion and analysis focuses on the areas of similarity and difference as well as any unique aspects of the three approaches deserving special attention. Additionally, this memo suggests alternative statutory provisions and additional considerations that should be addressed in a future study of the durable power of attorney for health care statutes in California. Ultimately, the reader should gain a better understanding of some of the improvements that could be made to existing California advance health-care directive law.

2. TERMINOLOGY

The UHCDA uses the phrase “advance health-care directive” to indicate an “individual instruction,” a “power of attorney for health care,” or a combination of one or more individual instructions and a power of attorney for health care contained in one document. UHCDA § 1(1). The term “individual instruction” means a person’s written or oral instruction concerning his or her health care other than a “power of attorney for health care.” UHCDA § 1(9). Also, the UHCDA uses the terms “power of attorney for health care,” “power of attorney,” and “power,” to mean a written document in which the principal authorizes one or more agents to make particular health-care decisions for the principal under certain circumstances. UHCDA §§ 1(12), 2(b). The use of three different terms to signify a power of attorney for health care would be misleading to a person exposed to these concepts for the first time, and California should not follow this example.

In contrast, California does not use the terms “advance health-care directive” or “individual instruction”; rather, California law authorizes an individual to execute a “durable power of attorney for health care” and/or a Natural Death Act “declaration.” Prob. Code §§ 4600-4806 (durable power of attorney for health care), 4900-4948 (judicial proceedings concerning powers of attorney); Health & Safety Code §§ 7185.5-7194.5 (Natural Death Act). A Natural Death Act “declaration,” analogous to an individual instruction, is a document executed in accordance with the applicable California law that specifies the individual’s desire to have life-sustaining health care withheld or withdrawn if the individual subsequently is permanently unconscious or terminally ill and lacks the capacity to make his or her own health care decisions. Health & Safety Code § 7186.5. In California, a “durable power of attorney for health care” is equivalent to the UHCDA’s terms “power of attorney for health care,” “power of attorney,” and “power.” Prob. Code §§ 4018, 4124, 4606. The terms “attorney-in-fact,” as used in the California statutes, and “agent,” as used in the UHCDA, mean an individual designated in a durable power of attorney for health care to make health-care decisions for the person granting the power. Prob. Code §§ 4014; UHCDA § 1(2). Because the term “attorney-in-fact” is used exclusively in a legal context, it is more likely to confuse a layperson than the term “agent,” which is more familiar and sometimes used in non-legal contexts. Thus, in order to clarify the terminology in existing law, the term “agent” could be substituted for “attorney-

in-fact” throughout the California durable power of attorney for health care statutes.

Where California uses the term “principal,” the UHCDA uses the terms “patient,” “principal,” or “individual” interchangeably to describe a person who executes a durable power of attorney for health care. Prob. Code § 4026; *See, e.g.*, UHCDA §§ 2(b)-(f). The UHCDA’s use of several terms with the same meaning is confusing and unnecessary, and should not be emulated in California law. Furthermore, California’s use of the term “principal,” a word with both legal and non-legal definitions, may be confusing to a layperson. Instead, the term “individual,” a word with essentially the same legal and non-legal meanings, could be used.

The definitions for the following terms are very similar in the California durable power of attorney for health care statutes and the UHCDA: “health care,” “health care decision,” and “health care provider.” Prob. Code §§ 4609, 4612, 4615; Health & Safety § 7186(c); UHCDA §§ 1(5), 1(6), 1(8), 1(12). One difference in terminology worthy of mention is that the definition of “health care” in the California durable power of attorney statutes specifically includes “decisions affecting the principal after death,” whereas the UHCDA and Natural Death Act do not expressly make this particular distinction. Prob. Code § 4609. This added clarification of the definition of “health care” is important and should not be removed or significantly modified, as it implies that the attorney-in-fact may properly be granted authority to make decisions concerning autopsy and organ donation.

The Natural Death Act defines several important terms not mentioned by the UHCDA or California durable power of attorney for health care statutes. For example, the Natural Death Act defines the terms “life-sustaining treatment,” “permanent unconscious condition,” and “terminal condition.” Health & Safety Code §§ 7186(d), 7186(e), 7186(j). The proper interpretation and application of each of these definitions to real-life circumstances depends on the reasonable professional judgment of a licensed physician.¹ Similar definitions could be included in California’s durable power of attorney for health care statutes in the

¹ For example, “terminal condition” “means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, within reasonable medical judgment, result in death within a relatively short time.” Health & Safety Code § 7186(j). Also, “permanent unconscious condition” “means an incurable and irreversible condition that, within reasonable medical judgment, renders the patient in an irreversible coma or persistent vegetative state.” Health & Safety Code § 7186(e).

form of mandatory definitions or default statutory definitions that apply unless otherwise specified in the durable power of attorney. On the one hand, statutory definitions might better protect principals from fraudulent, unreasonable, or poorly informed decisions made by attorneys-in-fact concerning the withholding or withdrawal of life-sustaining care. On the other hand, statutory definitions would limit individual autonomy unless the principal could otherwise specify his or her own definitions and, if desired, grant the appropriate authority to the attorney-in-fact.

Unlike California's durable power of attorney for health care law, which refers to any treating or supervising physician as a "health care provider," the UHCDA and Natural Death Act are more specific. The UHCDA uses the term "primary physician" to mean a physician designated by an individual in an advance directive or designated by the individual's agent, guardian, or surrogate to have primary responsibility for the individual's health care. UHCDA § 1(13). Similarly, the Natural Death Act uses the term "attending physician" to signify the same thing. Also, in the UHCDA the terms "primary physician" and "supervising health-care provider" mean a physician who, in the absence of a designation or if the designee is not reasonably available, undertakes primary responsibility for the individual's health care. UHCDA § 1(13), 1(16). One advantage to an increased degree of definitional specificity regarding health-care providers is that the likelihood of confusion among numerous physicians, nurses, and other medical personnel is diminished.

Finally, the UHCDA defines "capacity" as "an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision." UHCDA § 1(3). In contrast, there is no comparable statutory provision or case law in California that establishes the definition of "capacity" or "competence" for use in extra-judicial determinations of capacity or competence made by a physician, health-care provider, or layperson. Determinations of capacity will be discussed in more detail in a following section.

3. GENERAL PROVISIONS REGARDING ADVANCE HEALTH-CARE DIRECTIVES

A. Types of Advance Health-Care Directives

California law and the UHCDA permit an individual to designate another person or persons as authorized to make health care decisions for the individual

who granted the power in a durable power of attorney for health care. Prob. Code §§ 4600-4806 (durable powers of attorney for health care); UHCDA §§ 1(12), 2(b). A durable power of attorney for health care may specify the principal's wishes regarding life-sustaining and life-saving health care, including the principal's desire to have such care withheld or withdrawn or to forego resuscitative measures. Prob. Code § 4720(a); UHCDA § 2(b). If an individual does not wish to execute a durable power of attorney for health care, the UHCDA permits him or her to give an individual instruction. Analogous to a living will, an individual instruction may state the individual's wishes concerning one or more specific types of health care or health care in general, and it may be limited to take effect only if a specified condition arises. UHCDA § 1(9), Comment. Alternatively, an individual in California may specify his or her desire to have life-sustaining medical treatment withdrawn or withheld in a written declaration executed in accordance with the Natural Death Act, but by definition the declaration is limited to take effect only if the individual subsequently becomes permanently unconscious or terminally ill and lacks the capacity to make health-care decisions. Health & Safety Code §§ 7185.5(d), 7186.5(b).

Although there is no California equivalent to an individual instruction, a person may approximate an individual instruction in the following ways: by a durable power of attorney for health care that limits the attorney-in-fact's authority to making specific, enumerated health care decisions or decisions regarding particular categories of health care; by a Natural Death Act declaration; or by a "living will."²

Therefore, the main difference between California advance health-care directive law and the UHCDA is that the latter permits an individual, within one document, to specify his or her desires concerning one or more types of health care decisions, designate attorneys-in-fact, and nominate alternative decisionmakers other than attorneys-in-fact. This "all-in-one" approach lends itself to easily executed advance directives for health care that reflect most, if not all, of the individual's preferences concerning his or her health care both before

² A "living will" is any written declaration in which an individual states what medical treatment he or she desires or rejects at some future time under certain circumstances. It may apply to a wider range of circumstances and treatments than a Natural Death Act declaration can address, and it may allow for more personalized statements of the individual's wishes. Although there is no statutory basis for the creation and execution of a living will in California, a court would probably treat a living will as significant evidence of an individual's wishes regarding his or her health care.

and after death. Accordingly, the Commission should consider changing California law so that an individual may execute an all-in-one type of advance directive for health care.

B. Permissible Purposes

A durable power of attorney for health care executed in accordance with California law or the UHCDA, or an individual instruction executed pursuant to the UHCDA, may grant authority to make health-care decisions both before and after the principal's death to the same extent as the principal could make health care decisions if he or she had the capacity to do so, including decisions regarding the withholding or withdrawal of life-sustaining medical treatment and organ or tissue donation. Prob. Code §§ 4123(d), 4720(b); UHCDA § 2(b). In contrast, a declaration executed in accordance with the Natural Death Act is by nature limited to authorizing the attending physician to make health-care decisions for the declarant concerning life-sustaining treatment before and until the declarant's death. Health & Safety Code § 7185.5 (d). This limitation would be removed if the all-in-one approach were adopted in California, because an individual could decide in the form of an individual instruction or set of instructions whether to permit the attending physician to make health-care decisions that affect the individual after his or her death.

C. Effect of Laws

The UHCDA, the Natural Death Act, and the California durable power of attorney for health care statutes provide that nothing in their provisions may be construed to condone, authorize, or approve mercy killing, nor to permit any affirmative or deliberate act or omission to end life other than the withholding or withdrawal of health care pursuant to an advance health-care directive, durable power of attorney for health care, or Natural Death Act declaration in order to permit the natural process of dying. UHCDA § 13(c); Prob. Code § 4723; Health & Safety Code § 7191.5(g). Furthermore, a death resulting from the withholding or withdrawal of life-sustaining health care performed in accordance with the Natural Death Act, California durable power of attorney for health care law, or the UHCDA, does not constitute a suicide or homicide. Health & Safety Code § 7191.5(a); Prob. Code § 4750(b); UHCDA § 13(b). Moreover, the UHCDA and Natural Death Act state that their respective provisions do not create a presumption concerning the intention of an individual who has not made or who has revoked an advance health-care directive or declaration. UHCDA § 13(a);

Health & Safety Code § 7191.5(d). Also, the UHCDA and the Natural Death Act provide that a death resulting from the withholding or withdrawal of health care in accordance with their respective provisions does not legally impair, affect, modify, or invalidate an insurance policy or annuity providing a death benefit, despite any term in the policy or annuity to the contrary. UHCDA § 13(b); Health & Safety Code § 7191.5(b). California's durable power of attorney for health care statutes do not have equivalent provisions.

D. General Obligations of and Limitations on Health-Care Providers and Third Parties

The California durable power of attorney for health care statutes, the Natural Death Act, and the UHCDA provide that a health-care provider, health-care service plan, insurer issuing disability insurance, self-insured employee welfare plan, or nonprofit hospital plan or similar insurance plan, may not condition admission to a facility, or the providing of treatment, or insurance, on the requirement that a patient execute a durable power of attorney for health care, Natural Death Act declaration, or UHCDA advance health-care directive. Prob. Code § 4725; Health & Safety Code § 7191.5(b)-(c); UHCDA § 7(h). These provisions not only follow the mandates of the federal Patient Self-Determination Act (42 U.S.C. § 1395cc(f)(1)(C) (Medicare); 42 U.S.C. § 1396a(w)(1)(C) (Medicaid)), but they also reduce the possibility that a health-care provider could use duress to cause an individual to execute an advance health-care directive of any kind. For these reasons, any future changes to the California durable power of attorney for health care statutes or other modifications to the law governing advance directives for health care in California should contain a provision similar to Section 4725 of the Probate Code or Sections 7191.5(b)-(c) of the Health and Safety Code.

Also, the UHCDA and the Natural Death Act specify that a health care provider or institution, and, under the Natural Death Act, an insurer, may not require or prohibit the revocation or non-execution of an advance health-care directive as a condition for providing health care or insurance for health care. UHCDA § 7(h) & Comment; Health & Safety Code § 7191.5(c). The California durable power of attorney for health care statutes do not contain an equivalent provision, nor does the UHCDA expressly include insurance plans or self-insured employee benefit plans, or specify that the provision of insurance is included in the prohibition. UHCDA § 7(h). The Commission should consider

adding a provision similar to Section 7191.5(c) of the Health and Safety Code to a revised version of the durable power of attorney for health care statutes in order to close up this loophole.

One unique feature of the UHCDA is the protective requirement that if possible, before implementing any health-care decision made on an individual's behalf, the supervising health-care provider must promptly communicate to the individual the decision made and the identity of the person who made it. UHCDA § 7(a). The only similar safeguarding provision in California's advance health-care directive law is the more limited requirement that if the decision made by an attorney-in-fact is to withhold or withdraw health care necessary to keep the principal alive, the treating health care provider must ask the principal what his or her desires are before complying with this decision, regardless of the principal's capacity or ability to communicate them. Prob. Code § 4750(a)(2). In practice, a provision such as Section 7(a) of the UHCDA would increase the protective measures taken on the principal's behalf without unreasonably adding labor-intensive tasks to the attending physician's duties. Accordingly, the Commission should consider adding a provision analogous to the UHCDA's Section 7(a) to the California durable power of attorney for health care statutes.

The UHCDA and Natural Death Act go further to reinforce the limits on a health-care provider's authority and the individual's right to grant such authority by providing that a health-care provider or institution is neither authorized nor required to provide health care contrary to generally accepted, reasonable health-care standards applicable to the health-care provider or institution. UHCDA § 13(d); Health & Safety Code § 7191.5(f). Although the California durable power of attorney statutes do not have an identical provision, Section 4750, subdivision (d), states that "[n]othing in this chapter authorizes a health care provider to do anything illegal." Prob. Code § 4750(d).

A health-care provider has an affirmative duty to record information in an individual's medical record under certain circumstances. For instance, a physician or other health-care provider who knows of a Natural Death Act declaration or of a revocation of a declaration must obtain a copy and place it in the declarant's medical record. Health & Safety Code §§ 7186.5(c), 7188(b), 7189. The UHCDA imposes similar requirements, providing that a supervising health-care provider who knows of an advance health-care directive, a revocation of an advance health-care directive, or a designation or disqualification of a surrogate must promptly record it in the patient's medical record. UHCDA § 7. In addition,

if it is in writing, the health-care provider must request a copy and place it in the patient's medical record if a copy is furnished. UHCDA § 7(b). The Commission should consider imposing similar recording requirements on every treating health-care provider in the California durable power of attorney for health care statutes to increase the likelihood that the individual's wishes in his or her advance directive will be known and observed.

E. Criminal or Civil Liability for Fraudulent Conduct

In California, an individual who willfully conceals, cancels, defaces, or obliterates a Natural Death Act declaration of another individual without his or her consent, or who forges or falsifies a revocation of another individual's declaration, is guilty of a misdemeanor. Health & Safety Code § 7191(c). Moreover, except where justified or excused by California law, any person who alters or forges another person's durable power of attorney for health care or Natural Death Act declaration, or willfully conceals or withholds personal knowledge of a revocation, with the intent to cause a withholding or withdrawal of health care necessary to keep the principal or declarant alive contrary to the desires of the principal or declarant, and directly causes health care necessary to keep the principal or declarant alive to be withheld or withdrawn, thereby hastening the death of the principal or declarant, is subject to prosecution for unlawful homicide. Prob. Code § 4726; Health & Safety Code § 7191(d). While I do not recommend any substantive changes to these provisions, perhaps they could be made easier to understand.

Surprisingly, the UHCDA takes a more limited approach, merely providing that a person who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health-care directive or revocation of an advance health-care directive without the individual's consent is subject only to civil liability. UHCDA § 10(b). The drafters apparently believed that criminal prosecutions were unlikely to occur, and accordingly chose to impose civil rather than criminal penalties. UHCDA § 10 Comment. Furthermore, the Comment to Section 10 recognizes that the damages provided in Section 10 do not supersede other remedies available under the law of the enacting state, but whether this includes criminal liability is unclear.

F. Validity of Advance Health-Care Directive Executed in Another Jurisdiction

In the absence of knowledge to the contrary, a health-care provider in California can presume that a durable power of attorney for health care or Natural Death Act declaration is valid, regardless of where it was executed. Prob. Code § 4752; Health & Safety Code § 7192. The UHCDA does not have an express provision concerning the presumption of an advance directive's validity. I do not recommend that any changes or modifications be made to Section 4752 because a presumption of validity is necessary to facilitate implementation of durable powers of attorney at the bedside.

Furthermore, a durable power of attorney for health care or similar instrument, or a Natural Death Act declaration executed in another state or jurisdiction in compliance with the laws of that state or jurisdiction or of California, is valid and enforceable in California to the same extent as a durable power of attorney for health care or Natural Death Act declaration validly executed in California. Prob. Code § 4653; Health & Safety Code § 7192.5. On the other hand, the UHCDA recognizes an advance health-care directive as valid if it complies with the UHCDA's minimal execution requirements, regardless of when or where it was executed or communicated. UHCDA § 2(h).

One advantage of the UHCDA's "minimal execution requirements" approach is that it would ensure that each durable power of attorney for health care would be executed with at least a minimum level of safeguards and protections of the type required by California law. However, merely requiring a durable power of attorney to comply with unknown statutes from another jurisdiction does not provide the same guarantee. Accordingly, I recommend that the Commission consider modifying Probate Code Section 4653 to make it similar to the UHCDA Section 2(h).

G. Conflict with or Existence of Other Advance Health-Care Directive

The UHCDA permits an advance health-care directive to be modified by a later one, providing that an advance health-care directive executed in accordance with the UHCDA that conflicts with an earlier advance health-care directive revokes the earlier one only to the extent of the conflict. UHCDA § 3(e). On the other hand, the default rule in California's durable power of attorney for health care statutes is that unless it provides otherwise, a valid durable power of attorney for health care revokes any prior durable power of attorney for health

care. Prob. Code § 4727(d). The Natural Death Act is silent with respect to resolution of conflicts among one or more declarations.

Also, California law provides that if an individual has executed both durable power of attorney for health care and a declaration executed pursuant to the Natural Death Act, the former prevails unless expressly provided otherwise in the durable power of attorney for health care. Health & Safety Code § 7193. The potential for confusion is great where two separate legal documents governing the same subject matter conflict. Although Section 7193 resolves this problem, it would be better resolved with the “all-in-one” approach, whereby an individual may specify his or her desires concerning one or more types of health care decisions, designate attorneys-in-fact, and nominate alternative decisionmakers other than attorneys-in-fact, all within one document.

H. Effect of Copy

The UHCDA recognizes that a copy of a valid written advance health-care directive, revocation of an advance health-care directive, or designation or disqualification of a surrogate has the same force and effect as the original. UHCDA § 12. The UHCDA does not specify the definition of “copy” or impose any particular requirements for the copy to be valid. In contrast, California law requires a copy of a durable power of attorney to be certified by an attorney, notary public, or other state official authorized to make certifications, and the certification must also include a declaration stating that the certifying person has examined both the original power of attorney for health care and the copy, and that the copy is a true and correct copy of the original. Prob. Code § 4307. The Natural Death Act is silent with respect to requirements for a copy of a declaration to be valid. Because the protective requirements in Section 4307 are important safeguards against fraud, they should not be significantly modified.

I. Effective Without Judicial Approval

A decision made in accordance with a valid power of attorney for health care and a health-care decision made by a guardian or surrogate pursuant to an individual instruction are effective without judicial approval or intervention, subject to any judicial proceedings commenced under §§ 4900-4948 of the Probate Code or in the case of the UHCDA, under the relevant statutes of the enacting state. Prob. Code § 4900; UHCDA §§ 2(f), 5(g), 6(c). Similarly, the Natural Death Act recognizes that in the absence of controversy, decisions regarding life-

sustaining health care should be made without judicial intervention. Health & Safety Code § 7185.5(e).

4. CREATION AND EFFECT OF ADVANCE HEALTH-CARE DIRECTIVES

A. Who May Execute An Advance Health-Care Directive

California permits any “natural person having the capacity to contract” to execute a power of attorney.³ Prob. Code § 4120. “An individual of sound mind and 18 or more years of age” may execute a declaration under the Natural Death Act. Health & Safety Code § 7186.5. Under the UHCDA, a power of attorney for health care or individual instruction may be executed by any adult or emancipated minor. UHCDA § 2(a)-(b). The question of whether unemancipated but mature minors may make an advance health-care directive is not addressed by the California durable power of attorney statutes, the Natural Death Act, or the UHCDA. The Commission should consider whether Probate Code Section 4120 or some other area of the California Codes should specifically address this issue.

B. Formalities

A power of attorney for health care executed under California law or the UHCDA must be in writing and signed by the principal. Prob. Code § 4124; UHCDA § 2(b). Alternatively, California permits the power of attorney to be signed in the principal’s name by some other person in the principal’s presence and at the principal’s direction. Prob. Code § 4121. Both of these provisions reduce the likelihood of fraud, with the latter provision allowing for circumstances in which the principal for any reason cannot sign the power of attorney.

A Natural Death Act declaration must also be in writing and signed by the declarant or by another person at the declarant’s direction and in the declarant’s presence. Health & Safety Code § 7186.5(a). In contrast, an individual instruction executed pursuant to the UHCDA may be oral or written. UHCDA § 2(a). There are no other requirements regarding witnesses, signatures, dating, or mandatory statements for an individual instruction or a power of attorney for health care

³ In California, the law presumes all persons except for minors, persons of unsound mind, and persons deprived of their civil rights to be capable of contracting. Civ. Code § 1556. Any person having capacity to contract may grant authority to an attorney-in-fact through a power of attorney. Civ. Code § 2296.

executed pursuant to the UHCDA to be valid and enforceable. UHCDA § 2(a). Although the UHCDA's relative lack of formal execution requirements lends itself to ease of execution, there are inadequate protections against fraud. Consequently, I do not recommend that California relax the formal execution requirements for the durable power of attorney for health care.

C. Witnessing, Notarization, and Warning Requirements

California law mandates detailed witnessing and other execution requirements for durable powers of attorney for health care and Natural Death Act declarations. For example, a power of attorney for health care must contain the date of execution and a statement to the effect that it is exercisable notwithstanding the principal's subsequent incapacity. Prob. Code §§ 4121, 4124. In some cases, a special warning statement is required in a durable power of attorney for health care. For instance, if the principal uses a pre-printed form designed for use by persons who do not have the advice of a lawyer, and if the form is not a statutory form durable power of attorney as described in Section 4771 of the Probate Code, the durable power of attorney may only authorize the attorney-in-fact to make health-care decisions, and the document must contain two particular warning statements. Prob. Code § 4703(a)-(c). These warning statements outline the principal's rights under the durable power of attorney for health care, the consequences of signing or not signing the power of attorney, the permissible scope of the agent's authority, and the execution requirements for a durable power of attorney for health care. Prob. Code § 4703(a)-(c).

Another example of when a warning statement is necessary is when the durable power of attorney for health care is prepared by an attorney on neither a pre-printed nor statutory form. Prob. Code § 4704. Here, not only must the durable power of attorney for health care contain the warning statement provided in Section 4703(a), but the attorney must also advise the principal of the applicable law and the consequences of signing or not signing the document, and the power of attorney must include a certificate signed by the principal's lawyer stating the substance of the advice given. Prob. Code § 4704(a)-(b). The UHCDA and the Natural Death Act do not have any of these additional protective requirements, possibly because their provisions contain less legalese and their respective optional forms are easier for a layperson to understand. But unless the durable power of attorney for health care statutes are greatly simplified, Sections 4703 and 4704 should not be modified or removed, as they establish important

safeguards necessary to ensure that a principal executes a durable power with full information and understanding of the relevant law.

Furthermore, a durable power of attorney for health care executed in California must either be acknowledged before a notary public⁴ or signed by at least two witnesses who satisfy the requirements of Section 4122 regarding witness qualifications. Prob. Code § 4121. A Natural Death Act declaration must be witnessed by two persons; notarization is not an option. Health & Safety Code § 7186.5(a). As an extra precaution, California law mandates several important requirements for witnesses designed to protect the principal or declarant from persons most likely to have ulterior or illegal motives. For instance, none of the following persons may act as a witness to the execution of a durable power of attorney for health care or Natural Death Act declaration: the attorney-in-fact, the principal's health care provider or an employee of the health-care provider, the operator or an employee of a community care facility, or the operator or an employee of a residential care facility for the elderly. Prob. Code §§ 4122, 4701(a); Health & Safety Code § 7186.5 (a).

Also, at least one of the witnesses may not be one of the following: a relative of the principal by blood, marriage, or adoption; a person who would be entitled to any portion of the principal's estate upon the principal's death under operation of law or a will existing at the time of execution of the durable power of attorney for health care. Prob. Code § 4701(c); Health & Safety Code § 7186.5(a). Moreover, the witness satisfying these qualification requirements must sign a declaration under penalty of perjury stating that the witness is complying with them. Prob. Code § 4701(b),(d); Health & Safety Code § 7186.5(b). Finally, if the principal is a patient in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman as designated by the California Department of Aging. Prob. Code § 4701(e); Health & Safety Code § 7187.

Although California's witnessing and execution requirements protect the principal from duress, fraud, mistakes, and ignorance, they significantly increase the complexity of the law and quite possibly reduce the number of durable powers of attorney that are executed. The UHCDA and several other jurisdictions generally do not have the same number or type of stringent execution requirements, ostensibly to make advance directives easier for a

⁴ If a statutory form durable power of attorney for health care is used, acknowledgment before a notary is not authorized. Prob. Code § 4773(a).

layperson to execute and understand. Thus, there is probably a tradeoff between safeguards and ease of execution and understanding that the Commission should recognize when evaluating these provisions for possible revision.

D. Designation of Agents

In short, the provisions regarding the principal's designation of agents provide adequate safeguards against conflicts of interest. For example, California law prohibits the following persons from being designated as attorney-in-fact in order to protect the principal from persons who might have a conflict of interest with the principal: the treating health-care provider or an employee thereof, an operator or employee of a community care facility, or an operator or employee of a residential care facility for the elderly. Prob. Code § 4702(a). However, if related to the principal by blood, marriage, or adoption, an employee of the treating health-care provider, community care facility, or residential health-care facility for the elderly may be designated as the attorney-in-fact. Prob. Code § 4702(b)-(c). Similarly, to protect the interests of vulnerable residents of long-term health care institutions, the UHCDA provides that unless related to the principal by blood, marriage, or adoption, an agent may not be an owner, operator, or employee of a residential long-term health-care institution at which the principal resides or is receiving care. UHCDA § 2(b). Remarkably, the UHCDA fails to expressly prohibit the treating health-care provider from acting as agent for another individual.

Furthermore, to protect persons with mental illness, the conservator of a person who is a conservatee under the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of the Welfare and Institutions Code) is prohibited from being designated as the attorney-in-fact unless the conservatee is represented by a lawyer, the power of attorney is otherwise valid, and the lawyer representing the conservatee signs a declaration essentially stating that the conservatee has been advised of his or her rights and the applicable law in connection with the power of attorney and that the conservatee has executed the power of attorney after this advisement. Prob. Code § 4702(d).

The California statutory form durable power of attorney for health care provides spaces for the principal to designate up to two alternate agents. Prob. Code § 4771, ¶ 9. Likewise, the UHCDA optional form also provides the principal with the opportunity to designate a "first alternate" agent, who may act if the principal revokes the primary agent's authority or if the primary agent is

not willing, able, or reasonably available to make a health care decision for the principal. UHCDA § 4, Part 1. Moreover, California limits the alternate attorney-in-fact's authority, providing that if a court terminates the authority of the attorney-in-fact under a statutory form durable power of attorney for health care, an alternate attorney-in-fact cannot act without court approval. Prob. Code § 4778. The UHCDA does not have an equivalent provision.

E. Authority of Attorney-in-Fact or Agent

Under both California law and the UHCDA, a power of attorney for health care remains in effect notwithstanding the principal's later incapacity. Prob. Code § 4125; UHCDA § 2(b). And unless the durable power of attorney provides otherwise, the attorney-in-fact does not have authority to make a particular health care decision if the principal is able to give informed consent with respect to that decision. Prob. Code § 4720(a); UHCDA § 2(c). Therefore, both California and the UHCDA permit a principal to provide that the attorney-in-fact's authority becomes effective immediately or upon the occurrence of some event other than the principal's incapacitation, but only through an express provision in the power of attorney for health care.

Furthermore, in order to protect a principal against unauthorized acts, California expressly provides that if the principal objects, the attorney-in-fact is not authorized to consent to health care or to the withholding or withdrawal of health care necessary to keep the principal alive. Prob. Code § 4724. Similarly, the UHCDA provides that its provisions do not affect an individual's right to make his or her own health-care decisions while having capacity to do so. UHCDA § 11(a)-(b). In brief, Section 4724 is necessary to prevent the attorney-in-fact from authorizing the withholding or withdrawal of life-sustaining care over the principal's objections, even though the attorney-in-fact may be acting in accordance with the principal's previously expressed wishes.

In California, a person who is designated as an attorney-in-fact in a durable power of attorney for health care has no duty to act and need not formally accept the designation unless he or she voluntarily agrees in writing to act. Prob. Code § 4230(a), (c). Similarly, an advance health-care directive executed pursuant to the UHCDA does not require formal acceptance by an agent, designated guardian, or surrogate; however, a duty to act does arise from either an express acceptance

of the designation or nomination, or through conduct implying acceptance.⁵ UHCDA § 4, Comment at 15. The Commission should address the question whether imposing a duty to act on an attorney-in-fact would better encourage acceptance of nominations and recognition of principals' wishes regarding their health care.

Moreover, California imposes limits on the attorney-in-fact's duty to act. For instance, reliance is not sufficient to impose a legal duty on the attorney-in-fact to make subsequent health-care decisions for the principal. Prob. Code § 4230 (b). However, once the attorney-in-fact has commenced a decision or transaction he must complete it. Prob. Code § 4230(b). And in any event, the attorney-in-fact may decline to participate in the making of health care decisions for the principal without being bound by the stated desires of the principal to the extent permissible by law, apart from the durable power of attorney. Prob. Code § 4720(d). The UHCDA does not contain provisions similar to Sections 4230(b), 4720(d), or 4230(b).

F. Limitations on Authority of Attorney-in-Fact, Agent, or Surrogate

In California, a durable power of attorney for health care may never authorize the attorney-in-fact to consent to commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion on behalf of the principal. Prob. Code § 4722. Section 4722 is yet another important protection that ensures that an incapacitated principal will never be subjected to traumatic and irreversible procedures and treatments unless he or she is able to give a contemporaneous informed consent. On the other hand, the UHCDA is more permissive, prohibiting an agent or surrogate from consenting to the admission of an individual to a mental health-care institution unless the individual's written advance health-care directive expressly grants this authority to the agent. UHCDA § 13(e).

G. Determinations of Capacity, Permanent Unconsciousness, and Terminal Illness

The UHCDA establishes a rebuttable presumption that an individual has the capacity to make a health-care decision, give or revoke any type of advance

⁵ Because formal acceptance might encourage agents to become familiar with the principal's personal values and views about health care and quality of life, the explanation to the UHCDA optional form encourages the principal to discuss his or her wishes with the designated agent(s) and to determine whether the agent is willing to act on his or her behalf. UHCDA § 4(13) & Comment at 15.

health-care directive, or designate or disqualify a surrogate. UHCDA § 11(b). Although California law also expressly establishes a rebuttable presumption that the principal has capacity to revoke a durable power of attorney for health care, it is silent with respect to whether there is a presumption that the principal has capacity to make other types of health-care decisions. Prob. Code § 4727(c). The Commission should address this omission, perhaps by expanding the scope of Section 4727 to include other types of health-care decisions.

Additionally, the UHCDA requires that unless otherwise specified in the written advance directive, a determination that an individual lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent, must be made by the primary physician. UHCDA § 2(d). Furthermore, once a determination is made, the primary physician must record it in the patient's health-care record and communicate the determination to the patient, if possible, and to any person who has authority at that time to make health-care decisions for the patient. UHCDA § 7(c). This approach to capacity determinations promotes individual autonomy by permitting the principal to choose between his or her agent and the primary physician.

On the contrary, there is no California authority, in any statutory provision or case law, that prescribes the proper method for nonjudicial determinations of capacity for individuals who have executed a durable power of attorney for health care or living will. However, the "Due Process in Competence Determinations Act" ("DPCDA") (Prob. Code §§ 810-814) may be a useful model from which new statutory provisions governing extra-judicial capacity determinations could be derived. The DPCDA codified the existing common law to create a uniform standard for judicial determinations of an individual's capacity for decisionmaking, including decisions concerning health care. The DPCDA applies only to capacity determinations made by the court in judicial proceedings, and does not affect the burdens of documentation on, or potential liability of, physicians who determine the capacity of patients to make medical decisions. Prob. Code § 812(e). Therefore, an attorney-in-fact, physician, health-care provider, or layperson is *not* required to follow the DPCDA test for capacity to make health-care decisions when assessing the principal's capacity to make informed health-care decisions for himself or herself. However, any attempt to codify capacity determinations made at the bedside will probably be met with fierce opposition from physicians, although support could come from insurance

companies and managed-care organizations. Accordingly, any proposed law revisions based on the DPCDA or any other model must take these groups' interests and issues into consideration.

On the other hand, the Natural Death Act prescribes a specific and simple procedure by which the declarant is deemed to lack capacity. In order for a declarant to be deemed lacking the capacity to make his or her own health-care decisions and a declaration to become effective, the Natural Death Act provides that the declarant's attending physician and a second physician, both of whom have personally examined the declarant, must determine the declarant to be "no longer able to make decisions regarding administration of life-sustaining treatment." Health & Safety Code § 7187.5. Upon a determination that a declarant lacks capacity, and if the declarant is diagnosed by the attending and secondary physicians to be terminally ill or permanently unconscious, the declarant's declaration becomes effective. Health & Safety Code § 7187.5.

To summarize, the Natural Death Act's approach to capacity determinations emphasizes protecting the patient from poorly made or fraudulent capacity determinations, whereas the UHCDA promotes individual autonomy. The Commission should evaluate the strengths and weaknesses of both approaches, in addition to reviewing the DPCDA's provisions, before drafting provisions regarding capacity determinations for principals who have executed durable powers of attorney for health care.

H. Effect of Acts During Principal's Incapacity

An act performed or decision made by an attorney-in-fact pursuant to a durable power of attorney for health care during any period in which the principal is incapacitated has the same effect, inures to the benefit of, and binds the principal and the principal's successors in interest as if the principal had performed the act or made the decision while having capacity. Prob. Code § 4125. Likewise, the UHCDA permits a principal in a power of attorney for health care to "authorize the agent to make any health care decision the principal could have made while having capacity." UHCDA § 2(b). The Natural Death Act does not have a similar provision.

I. Springing Power of Attorney

The UHCDA and California law permit the principal to specify in the durable power of attorney for health care that the agent's authority becomes effective immediately, when the principal loses capacity, or upon the occurrence of an

event other than the principal's loss of capacity, but only by an express provision in the durable power of attorney. Prob. Code §§ 4129, 4720(a); UHCDA § 2(c) & Comment. Otherwise, the default rule is that the agent's authority is springing and becomes effective only upon the principal's loss of capacity. Prob. Code § 4720 (a); UHCDA § 2 (c).

J. Standard for Health-Care Decisionmaking

The UHCDA and California law require the attorney-in-fact or surrogate to act consistently with the principal's or patient's desires as expressed in the durable power of attorney for health care, advance health-care directive, or as otherwise made known to the attorney-in-fact or surrogate. Prob. Code § 4720(c); UHCDA §§ 2(e), 5(f). However, when the attorney-in-fact must infer the principal's desires from the principal's earlier conduct or statements, California law expressly provides that an attempted suicide by the principal may not be construed to indicate the principal's desire to restrict or limit any or all health-care treatment. Prob. Code § 4723. And if the principal's desires are unknown, the attorney-in-fact must act in the principal's best interests, which under the UHCDA specifically means considering the patient's personal values to the extent known to the attorney-in-fact or surrogate. Prob. Code § 4720(c); UHCDA §§ 2(e), 5(f).

Neither the UHCDA nor the California statutes prescribe a detailed list of factors for determining the principal's best interest; rather, the agent apparently has discretion to ascertain and weigh the factors likely to be important to the principal. However, in California, this authority is always subject to Section 4722, which proscribes the attorney-in-fact from consenting to certain types of treatment on the principal's behalf, including sterilization, abortion, and commitment to or placement in a mental health treatment facility. Prob. Code § 4722. In any case, the Commission should evaluate the advantages and disadvantages to a statutory requirement that the attorney-in-fact consider a list of general factors and principles when he or she makes a decision on behalf of the principal under the "best-interest" standard.

K. Duration of Advance Health-Care Directive

Unless a durable power of attorney for health care expressly states a time of termination, it remains in full force and effect indefinitely. Prob. Code § 4127. The UHCDA and the Natural Death Act are silent with respect to the duration of an advance health-care directive executed pursuant to their respective provisions.

L. Health-Care Information

The attorney-in-fact has the same right as the principal to receive information regarding the proposed health care, receive and review medical records, and consent to the disclosure of the principal's medical records, unless the durable power of attorney for health care or UHCDA advance health-care directive expressly limits these rights. Prob. Code § 4721; UHCDA § 8. The Natural Death Act does not have an equivalent provision.

M. Nomination of Surrogate Decisionmaker Other than Attorney-in-Fact or Agent

Both the UHCDA and California law permit a principal to nominate a conservator or guardian in a durable power of attorney for health care for consideration by the court if protective proceedings are commenced for the principal. Prob. Code § 4126; UHCDA § 2(g). The California statutory form durable power of attorney for health care and the UHCDA optional form advance health-care directive provide spaces for the principal to designate alternate agents who may act if the primary agent designee is not willing, able, or reasonably available to act, or if no primary agent has been designated. Prob. Code § 4771; UHCDA § 4(1). No provision is made in either the California statutory form or UHCDA optional form for the designation of co-agents, ostensibly to discourage the practice.

The UHCDA has a unique provision that permits an individual to nominate a "surrogate," a person other than an agent or guardian, who is authorized to make health care decisions for the individual upon the individual's loss of capacity if no agent or guardian has been appointed or if the agent or guardian is not "reasonably available." UHCDA § 1(17), § 5(a)-(j). As used in this context, "reasonably available" means "readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health-care needs." UHCDA § 1(14). An individual may make this nomination in writing either in an advance health-care directive or by personally informing the supervising health-care provider. UHCDA § 5(b).

As a protective measure, the UHCDA prohibits an owner, operator, or employee of a residential long-term health care institution at which the patient resides or is receiving care from acting as surrogate, unless he or she is also related to the patient by blood, marriage, or adoption. UHCDA § 2(b). Remarkably, the UHCDA fails to expressly prohibit the treating health-care

provider from acting as surrogate for another individual. Moreover, surrogate nominations are easily revoked, as the patient may disqualify any person from acting as the patient's surrogate at any time, including a member of the patient's family, by means of a signed writing or by personally informing the supervising health-care provider. UHCDA § 5(h).

Finally, the UHCDA has two unique protective provisions designed to safeguard patients from impostors who attempt to assume authority as surrogates. First, a supervising health-care provider may require an individual claiming surrogate status to provide a written declaration under penalty of perjury stating a sufficient basis for the claimed authority. UHCDA § 5(j). Second, a surrogate who assumes authority must promptly contact the patient's family of the assumption of authority. UHCDA § 5(d). Equivalent provisions could be added to the California durable power of attorney for health care statutes in order to further protect a principal from an impostor who attempts to assume authority as attorney-in-fact.

5. OVERVIEW OF STATUTORY AND OPTIONAL FORM ADVANCE HEALTH-CARE DIRECTIVES

A. Natural Death Act Optional Form Declaration

The optional form Natural Death Act declaration is very short and simple, and consists of three parts. The first of these parts is a statement summarizing the declarant's desire to have his or her attending physician withdraw or withhold life-sustaining health care in certain specified circumstances. Health & Safety Code § 7186.5(b). Each of the other two parts is a statement from each witness attesting to the voluntariness of the declarant's signature and the witness' compliance with and qualification under the requirements in Section 7186.5, subdivisions (a) and (b). Health & Safety Code § 7186.5(b).

Although the declarant is free to draft his or her own declaration, it must substantially contain the statements in the optional-form declaration. Health & Safety Code § 7186.5(b). Additionally, the Natural Death Act requires the declaration to contain a statement to the effect that if the declarant is diagnosed as pregnant, and the physician knows of this diagnosis, the declaration will have no force or effect during the pregnancy. Health & Safety Code § 7186.5(b). Surprisingly, neither the UHCDA nor the California durable power of attorney for health care statutes address the question whether a principal's pregnancy

nullifies, suspends, or in any way affects the operation of an advance health-care directive.

B. UHCDA Optional Form Advance Health-Care Directive

The UHCDA contains an optional form advance health-care directive that may be completed or modified in full or in part by an individual. UHCDA § 4. Alternatively, an individual may use a different form, so long as it complies with the UHCDA's substantive provisions. UHCDA § 4. Like the optional form Natural Death Act declaration, the language and terminology used throughout the UHCDA optional form are relatively simple and easy to understand. In some parts of the form, the individual has the opportunity to check a space next to pre-determined choices corresponding to a desired instruction, decision, or health care. *See, e.g.,* UHCDA § 4, Parts 1(3), 2(6), 2(7), 3(10). In the alternative, the individual may state his or her own wishes in blank spaces provided in the form. *See, e.g.,* UHCDA §§ 1(2), 2(8), 2(9), 3(10)(b). Any part or sub-part of the form which is not required to be completed by the UHCDA is labeled "OPTIONAL." *See, e.g.,* UHCDA § 4, Parts 1(1), 3, 4(11).

There are explanatory statements at the beginning of the optional form that outline the general rights, responsibilities, duties, and limitations on the individual, his or her agent, and third parties that arise from the execution of an advance health-care directive in accordance with the UHCDA. UHCDA § 4. The body of the optional form consists of four main parts. Part 1 is a power of attorney for health care in which the agent is granted authority to make all health-care decisions for the principal subject to any limitations the principal may state on blank lines in Part 1(2) of the form. UHCDA § 4. Also in Part 1 is a statement describing the agent's obligation to make health-care decisions for the principal according to the principal's wishes and in the best interests of the principal, and a statement nominating the designated agent or alternate agents as guardian if the need arises. UHCDA § 4.

In Part 2 of the optional form, entitled "Instructions for Health Care," an individual may specify his or her wishes regarding certain enumerated types of end-of-life health care, including prolongation of life in the event of a terminal illness or permanent unconsciousness, artificial hydration and nutrition, and pain relief. UHCDA § 4. Part 3 gives the individual the opportunity to specify his or her wishes concerning the donation of organs and tissues at death. UHCDA § 4. Part 4 permits the individual to designate a "primary physician" and an alternate

designee, and states that a copy of the form has the same effect as the original. UHCDA § 4. In addition, Part 4 provides space for the individual to sign and date the form and, at the individual's option, there are spaces for two witnesses to sign and date it. UHCDA § 4.

C. California Statutory Form Durable Power of Attorney for Health Care

A person is free to use a durable power of attorney that is not a statutory form as provided in Sections 4771 and 4774, as long as it complies with the requirements of Probate Code Sections 4600-4752. Prob. Code § 4779. At the beginning of the optional statutory form durable power of attorney for health care are several pages of warning and explanatory statements in all-capital letters that outline the general rights, responsibilities, duties, and limitations on the principal, his or her attorney-in-fact, and third parties that arise from the execution of a valid durable power of attorney for health care in accordance with California law. Prob. Code § 4771. In comparison with the Natural Death Act and the UHCDA, these warnings and explanations are difficult to read, verbose, and are more often in narrative rather than outlined form. However, in a small attempt to make the form and its terminology easier for a layperson to understand, the California statutory form durable power of attorney for health care uses the term “agent” instead of “attorney-in-fact.” Prob. Code § 4771. Furthermore, the form includes parenthetical instructions to guide the principal. See, e.g., Prob. Code § 4771, ¶¶ 1, 3-5, 8-11.

In short, most of the statutory form is similar to the corresponding provisions in the UHCDA optional form advance health-care directive and the Natural Death Act optional form declaration, with a few significant exceptions. First, the sections entitled “Inspection and Disclosure of Information Relating to My Physical or Mental Health” and “Signing Documents, Waivers, and Releases” are unique; no part of the UHCDA optional form or Natural Death Act optional form declaration expressly addresses medical information, medical records, or the attorney-in-fact's authority to sign health-related documents. Prob. Code § 4771, ¶ 6. Second, the statutory form expressly states that an agent has authority to authorize an autopsy; there are no equivalent express provisions in the UHCDA optional form or the Natural Death Act optional form declaration. Prob. Code § 4771, ¶ 7. Third, the statutory form durable power of attorney for health care provides a space for the principal to state the date the power of attorney expires, if the principal does not want the power of attorney to exist indefinitely. Prob.

Code § 4771, ¶ 8. And finally, the statutory form contains a paragraph entitled “Prior Designations Revoked” that automatically revokes any prior durable power of attorney for health care. Prob. Code § 4771, ¶ 11.

6. REVOCATION OF ADVANCE HEALTH-CARE DIRECTIVES

A. Presumption of Capacity To Revoke

The California and UHCDA provisions concerning the revocation of an advance health-care directive strive to promote individual autonomy. In California, a principal is presumed to have the capacity to revoke his or her durable power of attorney for health care, and a declarant may revoke his or her Natural Death Act declaration at any time and in any manner without regard to his or her mental or physical condition. Prob. Code § 4727(c); Health & Safety Code § 7188(a). Similarly, the UHCDA presumes that an individual has capacity to revoke any advance health care directive, including a power of attorney for health care, and to disqualify a surrogate. UHCDA § 11(b).

B. Revocation and Recording Requirements

At any time while having capacity to execute a durable power of attorney for health care, the principal may revoke the appointment of the attorney-in-fact by notifying him or her either orally or in writing; alternatively, the principal may revoke the attorney-in-fact’s authority to make health care decisions by notifying the health-care provider either orally or in writing. Prob. Code § 4727(a). The UHCDA is more permissive, granting an individual the broad power to revoke or replace all or part of an advance health-care directive, except for the designation of an agent, at any time and in any manner that communicates an intent to revoke. UHCDA § 3(b). However, an individual may revoke the designation of an agent only by a signed writing or personally informing the supervising health-care provider. UHCDA § 3(a).

If notified by the principal, a health care provider in California must record the principal’s revocation of the authority granted to the attorney-in-fact in the principal’s medical record and make reasonable efforts to notify the attorney-in-fact of the revocation. Prob. Code § 4727(b). Likewise, the health care provider must record the declarant’s revocation of his or her Natural Death Act declaration in the declarant’s medical record. Health & Safety Code § 7188(b). Under the UHCDA, a health care provider, agent, guardian, or surrogate who is informed of a revocation must promptly communicate the fact of the revocation

to the supervising health care provider and to any health-care institution at which the patient is receiving care. UHCDA § 3(c).

The UHCDA imposes additional recording requirements to reduce the risk that a health-care provider, agent, guardian, or surrogate might rely on an outdated individual instruction or the decision of an individual whose authority had been revoked. For instance, a supervising health-care provider who knows of a revocation of an advance health care directive, a designation of a surrogate, or a disqualification of a surrogate must promptly record this knowledge in the principal's medical records. UHCDA § 7(b). Also, if the revocation is in writing, a supervising health-care provider must request a copy of it; if it is furnished, the supervising health-care provider must place it in the principal's medical record. UHCDA § 7(b). The Commission should consider adding similar recording requirements to the durable power of attorney for health care statutes.

C. Revocation of Spouse Attorney-in-Fact or Agent

The principal's designation of his or her spouse as attorney-in-fact to make health care decisions is automatically revoked upon the dissolution or annulment of the principal's marriage to the spouse, unless the durable power of attorney expressly provides otherwise. Prob. Code § 4727(e). Likewise, under the UHCDA a decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as agent unless otherwise specified in the decree or the power of attorney for health care. UHCDA § 3(d). The California durable power of attorney for health care provisions are unique because of the default rule that a remarriage revives a designation if it was revoked solely because of subdivision (e) of Section 4727. Prob. Code § 4727(e).

7. PROTECTIONS AND IMMUNITIES

A. Overview

The UHCDA and California law provide that a health-care provider or institution acting in good faith and in accordance with generally accepted health-care standards applicable to the health-care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for complying with the health-care decision of a person with apparent authority to make decisions on the patient's behalf, or for declining to comply with a health-care decision of a person believed to lack authority, where the health-care provider or institution assumed in good faith that the directive was valid when

made and had not been revoked or terminated. Prob. Code § 4750(a)(1)-(2); Health & Safety Code § 7190.5(a)-(b); UHCDA § 9 (a). This immunity applies to the health-care provider or institution's compliance with decisions made by a person with apparent authority on behalf of the patient regarding the withdrawal or withholding of life-sustaining health care. Prob. Code § 4750(a); Health & Safety Code § 7190.5(a); UHCDA § 9(a)(1). In a related provision, the UHCDA provides that an individual acting as agent or surrogate under the UHCDA is not subject to civil or criminal liability or to discipline for unprofessional conduct for health-care decisions made in good faith. UHCDA § 9(b).

Also, California adds the additional protective requirement that if the decision is to withhold or withdraw health care necessary to keep the principal alive, the health-care provider must make a good faith effort to determine the desires of the principal to the extent the principal is able to communicate them to the health-care provider, and the results of that effort must be recorded in the principal's medical record. Prob. Code § 4750(a)(2). Thus, in California a health-care provider or institution has a duty to investigate the validity of a request to withhold or withdraw life-sustaining health care made pursuant to a durable power of attorney, and must ask the principal about his or her wishes regarding life-sustaining health care. There is no equivalent duty under the UHCDA or the Natural Death Act.

B. Physician or Other Health-Care Provider Unwilling To Comply

California law and the UHCDA provide that a health-care provider or institution is not subject to criminal prosecution, civil liability, or professional disciplinary action for declining to comply with a health-care decision or individual instruction to withdraw or withhold life-sustaining health care made pursuant to a durable power of attorney, Natural Death Act declaration, or UHCDA advance directive. Prob. Code § 4750(c); Health & Safety Code § 7190; UHCDA § 7(e). However, if the health-care provider or institution declines to comply, the UHCDA and the Natural Death Act require the health-care provider or institution to transfer the patient to another health-care provider or institution that is willing to comply with the instruction or decision. UHCDA § 7(g)(3); Health & Safety Code § 7190. The California durable power of attorney for health care statutes do not contain a comparable provision. Furthermore, the UHCDA is unique because it expressly requires the health-care provider or institution to

inform the patient and the patient's surrogate decisionmaker of the health-care provider's decision to not comply with the individual instruction or health-care decision. UHCDA § 7(g)(1).

Unlike any provision in California law, the UHCDA expressly limits the grant of immunity for health-care providers to two circumstances. First, the health-care provider or institution may decline for reasons of conscience. UHCDA § 7(e). Moreover, in the case of a health-care institution, the institutional policy based on reasons of conscience with which the proposed health-care decision conflicts must be promptly communicated to the patient or his or her authorized surrogate decisionmaker. UHCDA § 7(e). Second, a health-care provider or institution may decline to comply with a health-care decision or individual instruction that "requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution." UHCDA § 7(f).

8. MISCELLANEOUS PROVISIONS OF INTEREST

A. Judicial Proceedings

The UHCDA and the California power of attorney statutes permit the individual who is the subject of an advance health-care directive and his or her agent or attorney-in-fact, guardian, or surrogate to petition the court regarding an advance health-care directive or durable power of attorney for health care. UHCDA § 14; Prob. Code §§ 4900-4948. In addition, California permits other persons such as the principal's spouse, a relative, a court investigator, and any other interested person or friend to petition the court regarding the durable power of attorney for health care. Prob. Code § 4940. Moreover, California generally does not permit the durable power of attorney for health care to limit the authority of the attorney-in-fact, principal, principal's conservator, or public guardian. Prob. Code § 4903(b)(1)-(3).

B. Registration with Secretary of State

Unlike the UHCDA or Natural Death Act, the California durable power of attorney for health care statutes provide for a statewide registry system for information regarding an individual's durable power of attorney for health care. Prob. Code § 4800-4806 (Registration of the Durable Powers of Attorney for Health Care with Secretary of State). The intent is to register information such as the registrant's name and the document's location in a centralized database

accessible by any health-care provider, public guardian, or other person authorized by the registrant. Prob. Code § 4800.

C. Request to Forego Resuscitative Measures

In California, a request to forego resuscitative measures from an attorney-in-fact or legally recognized surrogate health-care decisionmaker made pursuant to a durable power of attorney for health care must be a written document signed by the principal, or signed by his or her legally recognized surrogate health-care decisionmaker and a physician, that directs a health care provider to forego resuscitative measures. Prob. Code § 4753(b). It must also include a statement from the attorney-in-fact or other legally recognized surrogate decisionmaker attesting to the fact that the surrogate acknowledges the request to be consistent with the known desires of and the best interests of the individual who is the subject of the form. Prob. Code § 4753(c). The UHCDA and the Natural Death Act do not have comparable provisions.

D. Optional Limits on the Application of Statutes

The California durable power of attorney for health care statutes strive to promote individual autonomy by permitting a principal to limit the application of most of the provisions concerning durable powers of attorney for health care by an express statement or inconsistent rule in the power of attorney, with a few exceptions. Prob. Code § 4101(a)-(b). A durable power of attorney for health care may not limit the application of the statutes concerning warnings or notices, execution formalities, qualifications of witnesses and attorneys-in-fact, protection of third parties from liability, and the ability of certain individuals to petition the court regarding the durable power of attorney for health care. Prob. Code §§ 4101, 4903. Neither the UHCDA nor the Natural Death Act expressly permits an individual to limit the application of one or more statutory provisions. However, because the UHCDA has fewer execution and other requirements than the analogous California statutes, the UHCDA and Probate Code Section 4101 may promote individual autonomy equally well.

9. CONCLUSION

To summarize, the UHCDA is less detailed and more permissive than the comparable California law, perhaps because the UHCDA's drafters designed it with simplicity and individual autonomy in mind. UHCDA Prefatory Note at 1.

The UHCDA optional form advance directive for health care in plain language accommodates individual instructions, a durable power of attorney for health care, and other health-care preferences, and consequently lends itself to simplicity and ease of execution. As a result, the UHCDA may reduce the likelihood that a layperson would need to consult an attorney or health-care provider in order to execute an advance health-care directive.

On the other hand, California's durable power of attorney for health care statutes are relatively complex, probably because they are designed to safeguard vulnerable individuals against conflicts of interest and fraud. The result is that a layperson may be more likely to need or to think he or she needs expert advice from an attorney in order to properly comply with the law. In turn, this could reduce the number of persons who actually execute valid durable powers of attorney for health care. And although the Natural Death Act contains protective provisions similar to the California durable power of attorney for health care statutes, it is less complicated, probably easier for the non-lawyer to understand, and may therefore better promote individual autonomy.

To summarize, if California is going to change its durable power of attorney for health care statutes, the only direction to go is toward simplification. And because simplification will unavoidably whittle away at California's many protective requirements, the Commission will have to decide early on what its priorities are — ease of execution and individual autonomy or safeguards against fraud and abuse.
